

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003444
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Deirdre Byrne
Support inspector(s):	Angela Ring;
Type of inspection	Unannounced
Number of residents on the date of inspection:	17
Number of vacancies on the date of inspection:	3

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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 06 January 2015 09:30 To: 06 January 2015 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
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the first monitoring inspection of this designated centre for adults with a disability by the Health Information and Quality Authority (the Authority). The purpose of the inspection was to assess 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. The designated centre is part of the Cheshire Foundation in Ireland (trading as Cheshire Ireland). At this inspection, the inspectors met with residents, staff members and relatives. Inspectors also met the person in charge who was present throughout the inspection. Inspectors did not meet the person nominated on behalf of the provider (the provider) at this time.

Inspectors followed up on unsolicited information that had been received prior to the inspection. These matters were reviewed and discussed with the person in charge during the inspection.

The designated centre consists of one unit located in an urban area, which is in close proximity to the local community, city centre, shops and good access to public transport. Overall, inspectors found that residents received a good quality of service in the centre. The centre can accommodate up to 20 persons, with a maximum of 17

residents currently residing in the centre. Inspectors met many of the residents during the inspection. Staff supported residents in making decisions and choices about their lives. Inspectors found that residents were comfortable and confident in telling inspectors about their lives and their home.

Inspectors found evidence of good practices across most of the nine outcomes monitored. Residents were familiar with the staff, and were supported to make choices in accordance with their needs, interests and capabilities. The staff were familiar with the residents needs and were observed to speak to them in a respectful and dignified manner. There were suitable fire safety procedures in place with regular fire drills in the centre.

However, inspectors found areas of non compliance over the nine outcomes monitored. These included a comprehensive assessment of residents needs, the completion of personal plans; the management of behaviours that challenge required review. There were also improvements required in the management of complaints, aspects of medication management and the management of risk.

Inspectors found an annual review of the safety and quality of care had not been carried out and the systems in place for the recruitment and supervision of staff also required review.

These non compliances are discussed in the body of the report and included in the action plan at the end of this report

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

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

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

Findings:

Inspectors reviewed only one component of this outcome in relation to the management of complaints.

Inspectors found there were systems in place for the management of complaints however, improvement were identified. While there was a policy on the management of complaints it not centre specific. For example, the complaints officer, the person to oversee the response and documentation of complaints, and the appeals process details were not included. While the complaints procedure was publicly displayed, it was not available in an accessible version for the residents.

The documentation of complaints reviewed by inspectors required improvement. Records of complaints were maintained by the person in charge. However, not all records provided to inspectors provided sufficient evidence they had been promptly investigated, what action had been taken and if residents were satisfied with the outcome as per Regulations. This is discussed under Outcome 18 (Records).

Residents and families informed inspectors they would talk to staff and the person in charge if they had any complaints or concerns. Some residents said the person in charge had an open door policy and was always available to them.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

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

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

Findings:

Inspectors found each resident's wellbeing was maintained by a good standard of care and support. However, improvements were required in the overall assessment process and development of personal plans for each resident. Improvements were also identified to ensure all residents had opportunities to participate in meaningful activities appropriate to their interests.

There was evidence that residents' welfare and wellbeing was maintained by a good standard of care and support, and by staff who were familiar with their health care needs. The residents had a moderate to severe physical disability which required staff support and assistance. However, the model of care provided was based on a medical approach that lacked residents social and emotional needs. While residents' health care needs were regularly assessed, a comprehensive assessment of their personal and social care needs was not completed. Inspectors spoke to residents who described their interests and the range of activities and areas of interest they participated both internally and externally. The residents' plans did not provide sufficient information on their specific social, emotional, participation needs and preferences. Additionally, behaviour support plans had not been developed for residents where required. Apart from health care, there was no evidence that personal plans impacted positively on the lives of the residents. The residents were not provided with copies of their personal plans in an accessible format. These matters were discussed with the person in charge and senior staff during the inspection, who acknowledged improvement was required.

Inspectors reviewed a sample of residents' medical plans in place. The assessments completed were evidence based and completed at regular intervals or as required. Inspectors found the care plans in place for residents identified needs were detailed to guide practice regarding issues such as, percutaneous gastrostomy (PEG) tube feeding, catheter care and management of dysphagia.

Inspectors found the overall provision of activities for residents required improvement. During the inspection, a number of residents went to day service or on trips to the community. However, a number of residents also remained in the centre during the day.

There appeared to be little activities for them to do. Some residents told inspectors there was not enough provided. Inspectors met the activities coordinator who came in from leave to meet them. She outlined the programme of range of activities provided for residents which included group activities, one to one time, baking, singing and games. However, these only took place three days per week.

Inspectors found residents were supported to move between services. A community transition coordinator had been appointed to liaise with the residents during any transition that may take place. The person in charge outlined the process that had taken place for previous residents, and that this would be mirrored for other residents. Inspectors found any discharges or transitions from the centre to the community were carried in a planned manner and in consultation and discussion with residents and their representatives.

Judgment:

Non Compliant - Major

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:

Inspectors found there were measures in place to ensure the health and safety of residents, staff and visitors to the designated centre was promoted and protected. However, improvements were identified in relation to the assessment of risk and the management of adverse events.

Inspectors found the assessment of risk required improvement. There was a risk management policy that met the requirements of the Regulations. However, it was not fully implemented in practice in relation to the risk assessment of potential hazards. For example, a risk register only contained risk assessments of lap-belts and bedrails. In addition, a number of areas of potential risk identified by inspectors had not been assessed. For example, the open entrance, electrical equipment in residents' bedrooms, and risk assessments for residents who smoked. Inspectors saw that risk was discussed from minutes read of health and safety meetings.

There were systems in place to discuss and monitor risk. A health and safety officer had recently been appointed who carried out weekly health and safety checks. The health and safety officer was due to complete formal training in this area in the near future.

There were systems in place to manage adverse events. An accident record book was

read by inspectors, in which a range of incidents were recorded. The person in charge informed inspectors that he reviewed all incidents in the incident log and these were also forwarded to the board of management. However, improvements were identified. as there was no evidence if investigations had taken place for example, medications errors and falls. In addition, there was no evidence of the action taken to prevent a similar incident re-occurring.

A health and safety statement was seen by inspectors. Inspectors saw and read an emergency evacuation plan, which included the alternative accommodation options. Personal emergency evacuation plans were in place for each resident and reviewed monthly.

A policy on the prevention and control of infection was read by inspectors. While the policy was not comprehensive enough to provide sufficient guidance to staff, inspectors were informed a suite of infection control policies were in draft format with plans to implement them in the centre in the immediate future. These were forwarded to inspectors after the inspection.

There was a policy on the management and prevention of fire, with an area of improvement in the documentation of practices carried out and training for staff. Inspectors saw fire exits were unobstructed and read daily checks that were completed by staff. However, a record had not been completed since the 29 December 2014. There were regular staff fire drills. Inspectors saw records were maintained for drills and they included the findings and any learning required. However, there was no record of the most recent fire drill carried out. This is discussed under Outcome 18.

Staff were able to tell inspectors what they would do if the fire alarm went off. Inspectors saw documented evidence that fire equipment was serviced regularly such as fire extinguishers, fire alarms and emergency lighting. Fire evacuation plans were displayed throughout the centre. Records reviewed by inspectors indicated that most staff had participated in fire training within the past three years. However, records read indicated some staff had not received training since 2008. This is discussed in more detail under Outcome 17.

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:

Inspectors found there were measures in place to promote the safeguarding of residents and protect them from the risk of abuse and a restraint free environment was promoted. However, improvements were identified in relation to behaviour supports and training in the prevention of abuse.

There were good practices in the management of behaviours that challenge. However, improvement were required to ensure compliance with the Regulations. A small number of residents presented with behaviours that challenged. These were discussed with the person in charge who was very familiar with each resident and described the triggers to their behaviour and the de-escalation techniques. However, while there was a policy in place, it was located within the safety statement and did not fully guide staff practice on the provision of positive support. This issue is discussed under Outcome 18. Also, positive behaviour support plans had not been developed and incorporated into the personal plans for these residents. This could lead to inconsistent practices amongst staff. This non compliance is detailed under Outcome 5 (social care needs).

Inspectors read policies on the prevention of abuse and procedures to investigate an allegation of abuse. All staff on the day of the inspection were knowledgeable in the area of protection from abuse. While training records read confirmed staff had completed training, some records revealed staff had not completed training since 2010. See Outcome 18.

There had been no incidents, allegation or suspicions of abuse however, the person in charge had an adequate understanding of the procedures to follow to carry out an investigation. Inspectors were informed there was a standard referral form. However, inspectors noted the complaints report was used report allegations of abuse. This could present a risk if allegations of abuse were to be investigated as though they were a complaint, both of which are two very different types of concern. This matter is discussed under Outcome 18.

Inspectors read intimate care plans that had been developed for each resident, and incorporated into their personal plans. The plans were comprehensive and provided clear guidance to staff and reflecting the residents' wishes and procedures they liked to follow.

There were good practices in the management of restrictive practices which was limited to the use of lap belt and bedrails. There was a detailed policy in place to guide practice, that reflected the National Policy "Towards a Restraint Free Environment". Where residents used bedrails and lap-belts there was a risk assessment completed. There was evidence that residents provided consent, and where this was not possible, their representatives were consulted with. There was alternatives to the use of restraint considered however, these were not recorded in residents files. Although care plans had yet to be developed, inspectors were shown a draft risk assessment plan which was in

the process of being rolled out across to service and would address this deficit.

Residents were supported where necessary to manage their finances independently, and a policy was in place to guide practice. Inspectors reviewed the measures in place and found sufficient safeguarding systems were in place.

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:

Inspectors were satisfied that the provider had systems in place to ensure residents' health care needs were met and there was evidence of overall compliance with the Regulations.

Inspectors reviewed records that confirmed residents had access to a general practitioner (GP) of their choice. Primarily residents attended their GP at the surgery unless out-of-hours care was required in the centre. There was evidence of regular and timely access to medical practitioners where required.

The residents had varying degrees of physical disability that required a high level of clinical input. While the staff were observant and responsive to any changes in the health care status of the residents, there was a need for a more permanent level of supervision of clinical care. Currently there was a nurse present in the centre one day per week. This was discussed with the person in charge, who was acknowledged there was a deficit and a clinical need and was actively recruiting a new nurse. This is discussed under Outcome 18.

There was evidence of referral and regular consultation with allied health services as required by the residents. There was evidence of regular access to ophthalmic services, physiotherapy, occupational therapy, dietetic, and chiropody services available. Also, records confirmed referrals were made to psychological service externally as dictated by the residents needs. Interventions were documented and there was evidence that these were adhered to. There was evidence that where a resident refused treatment or intervention this was documented but also that every support was afforded.

A twice yearly proactive risk management plan was undertaken, and the staff document

this review. In addition, a range of clinical and health assessments were completed on a regular basis and more frequently where required. There were detailed care plans developed for each residents identified needs. Care evaluation and updates were completed by care workers each day.

The designated centre was provided with suitable catering facilities. While residents did not prepare their own meals, some residents could purchase their own food, and it would be prepared by the chef. The chef prepared all the residents meals apart from breakfast, where residents were encouraged to prepare this meal themselves. A table was set up with cereals, breads, fruits and juices each morning. All meals were generally eaten together in a dining room. Some staff were observed to take their lunch along with the residents. There was a good range of choice available at each meal and a menu was displayed in the dining room.

A satisfaction survey had been carried on two occasions in 2014 and changes had been made where comments to reflect comments from the residents. The chef was provided with residents most up-to-date dietary requirements and where relevant residents are supported with weight dietary advice or special dietary requirements. Food observed was nutritious and varied, and residents confirmed this with inspectors.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

Inspectors found that while policies and procedures were in place for the management of medications, significant improvements were required in the documentation of administration and prescription sheets and procedures for medication management.

A sample of administration and prescription sheets were read by inspectors. However, some improvements were identified in relation to the layout and information contained:

- the dates on some administration sheets were unclear
- the administration sheet signature space was pre-populated with medication dose
- there was no photo of residents in some cases
- times on prescription records did not correspond to administration records
- crushed medications were not individually prescribed by the GP.

There was evidence of recording of medication errors. However, as outlined under Outcome 7 (Health and Safety), there was no evidence of an investigation carried out to ascertain the cause of the error, and what learning or improvement had been brought about.

Inspectors read a policy on the management of medication practices. A new draft policy was in the process of being implemented in the centre. This was discussed with the nurse who came into the centre on the day of inspection, she explained that training was being provided to staff on the new policy.

Improvements were required in the procedures for self administration of medication. Some of the residents self administered their own medications, with encouragement and assistance provided by staff where possible. The risk assessment process was in the process of being reviewed. This nurse explained that all residents would have a new risk assessment completed in line with the self administration procedures in the new policy. Each resident had a secure locker in their room to store medications.

There was evidence of training for staff who administered residents medications. A detailed training programme had been carried out and staff were expected to do refresher training where improvements were identified. The person in charge assured inspectors that a member of staff trained in medication administration was on duty each day and night.

All residents medications were regularly reviewed by their GP. There were detailed internal audits of medication practices carried out, which were read by inspectors.

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 designated centre is part of a larger organisation with a defined management

structure. While inspectors found some governance arrangements were in place, improvements were required in relation to the systems in place to support and promote the delivery of a safe, quality service.

The person in charge of the centre was qualified and experienced. He had engaged in continuous professional development. While he was somewhat familiar with the Regulations there were some gaps in his knowledge of the regulations. For example, the requirements for completion of personal plans for residents, the supervision of staff, the provision of up-to-date mandatory training and the records required to be kept for staff.

The person in charge also oversees the management of another designated centre in the organisation. This was discussed with the person in charge who explained he spent four days per week in this designated centre, and one day in the other. Inspectors noted the residents were very familiar with the person in charge and they had an easy rapport with each other.

There were some clear management structures in place, for example the care support staff were supervised by the senior care staff and a care coordinator, who in turn reported to the person in charge who was the service manager.

Inspectors were informed management meetings had been held with the regional manager and the service manager several times a year in 2014. However, there was no record of the minutes of the meetings and it could not be ascertained what was discussed and decided at these meetings. The person in charge met with staff on a regular basis. Inspectors read minutes of some of these meetings although it was not clear what decisions were made.

The provider had yet to complete a report of the review of the safety and quality of the service as required by Regulations. While a medication audit was carried out, there was no system of reviewing the quality and safety of the service provided to residents in the designated centre. Inspectors were informed the provider had visited the centre on a number of occasions in the past year. However, there was no evidence of a report on the visits to the centre.

Judgment:

Non Compliant - Major

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:

Inspectors found there was an adequate number of the staff to meet the needs of the residents. However, improvements were required in the skill mix of staff. Improvements were also identified in relation to staff documentation and the system of supervision.

While there was an adequate number of staff on duty to meet the residents needs, inspectors were not satisfied there was an adequate staff skill mix present. For example, one nurse was present in the centre one day per week to provide clinical supervision. The person in charge acknowledged and informed inspectors interviews for new nursing staff were due to take place in the middle of January 2015.

Inspectors found 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 one reference and there were no references on file for another staff member.

Staff training records were reviewed. However, the records did not provide adequate evidence that all training provided was up-to-date as discussed under Outcomes 7 and 8. There was no formal system of staff supervision or appraisal. The person in charge informed inspectors that a new supervision policy was due to be implemented, and formal appraisals would be carried out with staff.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

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

Findings:

Inspectors reviewed this outcome in the context of the maintenance of records under

Section 6 of the Regulations.

Inspectors requested records pertaining to the general running of the centre at the start of the inspection. However, the records were not easily retrievable. For example, although records were stored in a safe and secure place, it took a number of requests to the person in charge to be provided with the documentation required to be reviewed.

There were gaps in some records required to be maintained by Schedule 4 of the Regulations. As outlined in Outcome 7, there were gaps in records of fire drill practices and checks of the fire safety checks.

Judgment:

Substantially Compliant

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:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003444
Date of Inspection:	06 January 2015
Date of response:	25 February 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The complaints procedure was not in an accessible format for residents.

The complaints procedure was not centre specific for example, it did not include details of the complaints officer, person nominated to oversee the management of complaints and the appeals processes.

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

Action Required:

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

A) Accessible formats of the complaints procedure for those residents who require it will be explored and sourced. Responsible Individuals: Service Manager/Service Coordinator/Service Quality Officer

B) The complaints procedure contains the titles of the individuals who can be contacted within the service and organisation as opposed to individuals names. This is to ensure that the procedure is up to date in the event of a change in staff member

A notice will be placed in the lobby and throughout the service outlining specific individuals names and telephone numbers who can be contacted in the event of a resident wanting to make a complaint or appeal the decision of a complaint where they are dissatisfied with the outcome

. Responsible Individuals: Service Manager/Service Coordinator/Service Quality Officer

Proposed Timescale: 01/04/2015

Theme: Individualised Supports and Care

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

Inspectors could not ascertain if all complaints made had been recorded and responded to as per the Regulations.

Action Required:

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

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

Service Quality Officer to carry out an audit of the complaints folder and electronic database for all complaints received in 2014 to ensure all complaints received have been logged and actions taken to resolve the complaint.

Service Quality Officer to meet with Service Manager to discuss the recording of complaints received and follow up actions taken. Database and Complaint form to be reviewed to ensure all relevant information in relation to complaints management and outcome is captured.

Responsible Individuals: Service Quality Officer/Service Manager

Proposed Timescale: 01/06/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

There was no evidence that a comprehensive assessment of residents' social and personal needs was carried out on an annual basis.

The social care needs of residents in relation to activation and recreation in the centre required improvement.

Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

A comprehensive review of each service users personal plan will be carried out (commencing on 28th February 2015) and to take place over a 6 month period.

Training will be provided to the relevant care staff / keyworkers by the clinical support services team.

Training schedule/completion dates:

- 6 staff trained by 27th March 2015
- 8 further staff trained by 29th May 2015
- 8 further staff trained 29th August 2015

The outcome will be comprehensive individualised personal plans, in an accessible format. The development of the plan will involve the service user (and relatives where appropriate) in which an individualised personal activities plan will be designed and implemented based on assessed need.

Responsible Individuals: Senior Care Workers/Care support Team

Proposed Timescale: 31/08/2015

Theme: Effective Services

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

Personal plans were clinical and did not outline residents individual needs, aspirations and choices.

Plans did not positively impact on the lives of residents.

Plans were not developed to meet all residents needs, for example, the management of behaviours that challenge.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

A comprehensive review of each service users personal plan will be carried out (commencing on 28th February 2015) and to take place over a 6 month period.

Training will be provided to the relevant care staff / keyworkers by the clinical support services team.

Training schedule/completion dates:

- 6 staff trained by 27th March 2015
- 8 further staff trained by 29th May 2015
- 8 further staff trained 29th August 2015

The outcome will be comprehensive individualised personal plans, in an accessible format. The development of the plan will involve the service user (and relatives where appropriate) in which an individualised personal activities plan will be designed and implemented based on assessed need.

This review will include identification, response and support mechanisms of behaviours that challenge, where required. Responsible Individuals: Nurse/Senior Care Workers/Keyworkers

Proposed Timescale: 31/08/2015

Theme: Effective Services

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

Personal plans were not in an accessible format for residents.

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:

As part of the comprehensive review of each service user's personal plan, accessible format options will be explored where the need has been identified.

Responsible Individuals: Nurse/Senior Care Workers /Keyworkers

Proposed Timescale: 31/08/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The risk management policy was not implemented in practice in relation to the assessment of risk in the centre.

Not all areas of risk as outlined in Outcome 7 of the report had been identified, assessed and monitored.

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:

A comprehensive risk register is being developed to ensure all risks are identified, assessed and controlled. This will be implemented throughout the organisation on a phased basis.

Responsible Individuals: National Risk Manager/Service Manager

Proposed Timescale: 31/05/2015

Theme: Effective Services

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

The system for investigating and learning from all adverse events required improvement.

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:

Follow up and learning achieved from reporting and reviewing an adverse event will be clearly documented on the adverse event form. A review of adverse events will take place at the Health and Safety Meetings and any learning achieved will be discussed and promoted here. Investigations will be clearly recorded and maintained by the Service Manager to ensure recommendations are actioned within a specific timeframe. All adverse events will be reviewed / monitored by the National Risk Manager and learning implemented throughout the organisation.

Responsible Individuals: National Risk Manager/Service Manager

Proposed Timescale: 16/03/2015

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 procedures for prescribing and administration of medications required improvement.

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:

All prescriptions will be reviewed by the Staff Nurse in the service and amended as necessary (to include photograph and specification for individual medications that require crushing), with ongoing liaison with each service user and their GP.

An audit of all prescription sheets and MAR sheets will be carried out to ensure both the prescription and MAR sheets correspond correctly (time, 24hr clock and legibility).

There will be liaison with the pharmacies involved as required.

Responsible Individuals : Nurse/Senior Care Workers

Proposed Timescale: 31/03/2015

Theme: Health and Development

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

The system of assessing residents who self administer medication required improvement.

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:

A risk assessment will be carried out for all service users currently self-administering medication by the Staff Nurse in the service, in line with the provider's revised Medication Management Policy. This will ensure that support and encouragement is provided to service users who wish to take responsibility for the management of their own medication.

Responsible Individuals : Nurse/Senior Care Workers

Proposed Timescale: 31/03/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

There was no system of monitoring and review of the safety and quality of care provided to residents.

Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

A quality and safety audit was carried out in Richmond Cheshire House on 16th April 2014 using an audit tool developed by Cheshire Ireland (with support from Joe Wolfe and Associates) and a report produced outlining the findings.

A schedule of quality audits for 2015 will be developed for Cheshire Irelands 17 designated centres throughout the organisation (including Richmond Cheshire House). This will be developed by 1st March 2015

A quality and safety audit will be carried out in Richmond Cheshire House in the coming months and a report will be produced by the auditor (who will be a member of staff external to Richmond Cheshire House) outlining areas of good practice and opportunities for improvement. This report will be reviewed and approved by the Registered Provider prior to its circulation to the Service Manager and relevant individuals. Following this an action plan will be developed by the Service Manager and Service Coordinator to ensure all areas of non-compliance are addressed. Progress around meeting the actions required will be monitored by the Service Quality Officer / Registered Provider.

Responsible Individuals: C.E.O./Service Quality Officer/Trained staff in the organisation/Service Manager/Service Coordinator

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

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

An annual review of the quality and safety of care in the centre had not taken place.

Action Required:

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

A quality and safety audit was carried out in Richmond Cheshire House on 16th April 2014 using an audit tool developed by Cheshire Ireland (with support from Joe Wolfe and Associates) and a report produced outlining the findings.

A schedule of quality audits for 2015 will be developed for Cheshire Irelands 17 designated centres throughout the organisation (including Richmond Cheshire House) by 1st March 2015

A quality and safety audit will be carried out in Richmond Cheshire House in the coming months and a report will be produced by the auditor (who will be a member of staff external to Richmond Cheshire House) outlining areas of good practice and opportunities for improvement. This report will be reviewed and approved by the Registered Provider prior to its circulation to the Service Manager and relevant individuals. Following this an action plan will be developed by the Service Manager and Service Coordinator to ensure all areas of non-compliance are addressed. Progress around meeting the actions required will be monitored by the Service Quality Officer / Registered Provider.

Responsible Individuals: C.E.O./Service Quality Officer/Trained staff/Service Manager/Service Coordinator

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

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

There provider has not produced a report on the safety and quality of care and support provided.

Action Required:

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

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

A quality and safety audit was carried out in Richmond Cheshire House on 16th April 2014 using an audit tool developed by Cheshire Ireland (with support from Joe Wolfe and Associates) and a report produced outlining the findings.

A schedule of quality audits for 2015 will be developed for Cheshire Irelands 17 designated centres throughout the organisation (including Richmond Cheshire House) by

March 1st 2015

A quality and safety audit will be carried out in Richmond Cheshire House in the coming months and a report will be produced by the auditor (who will be a member of staff external to Richmond Cheshire House) outlining areas of good practice and opportunities for improvement. This report will be reviewed and approved by the Registered Provider prior to its circulation to the Service Manager and relevant individuals. Following this an action plan will be developed by the Service Manager and Service Coordinator to ensure all areas of non-compliance are addressed. Progress around meeting the actions required will be monitored by the Service Quality Officer / Registered Provider.

Responsible Individuals: C.E.O./Service quality Manager/Trained staff/Service Manager/Service coordinator

Proposed Timescale: 30/06/2015

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 in the centre required review.

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:

The Service Manager is currently recruiting to fill a vacant CNM1 position within the service. In the interim, agency nursing staff will be sought commencing February 2015 to increase the nursing hours within the service.

A review of assessment of need will be carried out to ensure that the skill mix of staff is appropriate to the number and assessed needs of the service users. This assessment will be carried out by a team of staff working in the service. This team will be provided local training on assessing need and gathering the information (utilising the Northwick Park Assessment Tool). The process will be monitored and supported by the Clinical Support Services Team and Service Manager.

Responsible Individuals: Nurse/Senior Care workers/Care Support Workers/Service Manager

Proposed Timescale: 30/09/2015

Theme: Responsive Workforce

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

in the following respect:

There were gaps in the information required to be maintained for staff as per the Regulations.

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:

An audit of all staff files against the requirements within the regulations will be carried out by the service management / administrator. All reasonable efforts will be made to obtain (on a retrospective basis) any of the required documents identified as not being located within the files.

Responsible Individuals: Service Management Team/Administrator

Proposed Timescale: 01/05/2015

Theme: Responsive Workforce

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

Training records reviewed did not provide adequate evidence that staff had up-to-date mandatory training.

Action Required:

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

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

(A) All staff will have completed Person Moving & Handling training (3 groups) by February 28th 2015

(B) All staff will participate in certified Fire Safety Training (3 groups) to be completed by March 13th 2015

(C) Staff requiring refresher training in Adult Protection & Complaints Management will participate in training on Wednesday February 18th 2015.

An audit of training records will be carried out by the Service Manager every 6 months (or as required) to ensure all staff have attended all mandatory trainings within the required timeframes. If gaps are identified as a result of these audits, the required training will be sourced and provided.

Responsible Individuals: Service Manager/National Learning &Development Manager

Proposed Timescale: 31/03/2015

Theme: Responsive Workforce

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

There was no system of staff supervision.

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:

Organisationally Cheshire Ireland has introduced a performance management process to manage employees performance. This is a competency based one to one performance review system. Senior staff within Richmond Cheshire House attended training on the roll out of this system in 2014.

In February 2015, commencement of the roll out of this system will occur within the service. Completion of this roll out process will take 3 months.

In line the Performance Management system, the Service Manager will schedule 1:1 performance review meetings with staff who report directly report to him (e.g. Service Coordinator, Head of Support Services) on a regular basis. The minutes of these meetings will be recorded and agreed by both parties using the template form. The Service Coordinator will schedule meetings with the Senior Care workers and follow the system as above. The Senior Care workers have an assigned number of Care Support Staff who they are responsible for scheduling performance meetings and reviewing progress on a regular basis. All minutes of these meetings are recorded and meetings will be schedule to occur on a 6 weekly basis.

On the spot mentorship, guidance and supervision is also provided by Senior Staff within the service and any performance issues / training needs identified are addressed within a reasonable timeframe by the Service Management.

Responsible Individuals: Service Management Team

Proposed Timescale: 01/05/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Records were not fully maintained in respect of fire safety practices in the centre.

Records were not easily retrievable upon request during the inspection.

Action Required:

Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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)

- A review of the daily and weekly fire safety checks will be carried out every month during the Health and Safety Committee meeting commencing February 1st 2015.
- A 6 monthly audit of compliance with the Fire Safety Policy will be undertaken and this will include a check on the Fire Register to ensure that the required documentation is filed.

B)

- Due to the unannounced nature of the inspection, not all records were located in one specific area within the centre for the inspectors to access but throughout the centre and were not available immediately when requested as they had to be retrieved. To ensure all staff are aware of the location of all required documentation for an inspection, a review of the documentation required will be carried out and a log developed as to where these documents are located throughout the centre will be developed
- Responsible Individuals: Service Management Team

Proposed Timescale: 01/06/2015