

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
<b>Centre ID:</b>	OSV-0003456
<b>Centre county:</b>	Wicklow
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	The Cheshire Foundation in Ireland
<b>Provider Nominee:</b>	Mark Blake-Knox
<b>Lead inspector:</b>	Julie Pryce
<b>Support inspector(s):</b>	
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	21
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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: 22 January 2015 11:00 To: 22 January 2015 20:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
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 second 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 and to follow up on the first inspection conducted on 10 April 2015. The designated centre is part of the Cheshire Foundation in Ireland (trading as Cheshire Ireland). During the inspection the inspector met with residents and staff members and reviewed documentation including personal plans, policies and staff training records.

Some improvements had been made since the last inspection, for example, in the area of personal planning and in the quality of the evening meals. However several of the actions agreed following the last inspection had not been implemented, for example in the area of staffing levels and skills mix.

The improvements and the areas of non compliance are further discussed in the body of the report and included in the action plan at the end.

**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):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

Improvements had been made in this area since the last inspection. Personal plans were now in place for all residents. These plans included assessments and plans in the activities of daily living and healthcare needs. All aspects of healthcare delivery examined by the inspector were included. However, the implementation of some of the plans of care, for example, the provision of some personal care, was either not recorded or only intermittently recorded. Therefore the inspector was not satisfied that the delivery of care in these areas was effectively monitored or evaluated.

The emphasis of the personal plans was on the healthcare needs of residents, and while goals were set in relation to some of the social aspects of care, and staff could report that steps were being taken towards achieving these goals, these plans were not documented. In addition personal plans in relation to the management of challenging behaviour were not in place for those residents who required them, as further discussed under Outcome 8.

**Judgment:**

Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

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

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The inspector found that there were structures and processes in place in relation to the management of risk, and improvements had been made since the last inspection. For example, the risk management policy now contained all the information required by the regulations, and many individual risk assessments for residents had been put in place.

There was evidence that fire risk was managed appropriately. Fire orders were on display throughout the centre, emergency lighting was operational and fire exits unobstructed. Fire drills were carried out on a regular basis and clearly documented. All staff fire training was up to date and staff were aware of the actions which would be required in the event of an emergency.

Quarterly maintenance checks had been conducted on the alarm system and emergency lighting, and annual maintenance of fire extinguishers had taken place. However it had been noted at the last check that some fire equipment was listed as missing including a fire extinguisher from the hydro pool area. This equipment was still missing.

As outlined in Outcome 12, not all prescriptions for PRN(as required) medications included the conditions under which the medication should be administered, for example there was no protocol on place to guide staff in decision making in relation to the administration of rescue medications for a resident with epilepsy reviewed during the course of the inspection. The inspector was concerned as to how a decision would be made in an emergency, in particular by non-nursing staff, where no guidance was available. The information given by staff in relation to requesting guidance from nursing staff by phone differed from that offered by the person in charge, so that it was unclear which was the correct procedure to manage this risk.

**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):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

There were systems in place to ensure the protection of vulnerable adults from abuse. For example staff training had taken place for all staff members. All staff were able to demonstrate a knowledge of the types of abuse, the signs of abuse and the actions that they would be required to take in order to safeguard residents.

There had recently been an allegation of abuse, and the investigations relating to this were examined by the inspector during the course of the inspection. The investigation which had been undertaken by the organisation was appropriate, and led to a suitable action plan. The implementation of the action plans was described by staff and had been documented.

While staff could describe good practice in the management of behaviour, and residents had access to appropriate healthcare professionals to support the management of the behaviour, this information was not included in the personal plan of one resident whose plan was examined by the inspector, as discussed under Outcome 5.

**Judgment:**

Compliant

**Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

The person in charge was aware of the requirements of the regulations in relation to notifications to the Authority. However a recent allegation of abuse was notified to the Authority two and a half months after the event, and not within the required timeframe of three working days.

**Judgment:**

Non Compliant - Moderate

**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**

Health and Development

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

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

There was evidence of structures and processes in place to ensure that residents' healthcare needs were being met, and there had been improvements in the areas of assessments of need and personal planning since the last inspection. Each resident now had a detailed healthcare plan in place and all healthcare needs reviewed by the inspector were included in these plans. Staff were knowledgeable in relation to the healthcare needs of each individual resident.

Access to healthcare professionals such as a GP of residents' choice, a speech and language therapist and an out of hours GP service were appropriate to the assessed healthcare needs of the residents.

There had been significant improvements in the satisfaction of residents with the quality of evening meals since the last inspection, and all residents spoken to informed the inspector that they were now happy with the quality of all meals.

There was evidence of the provision of an appropriate diet for residents, including the input of the speech and language therapist for some residents, and the availability of a dietician when required. The recommendations of these healthcare professionals informed the healthcare plans, for example the requirement for a modified diet. Records of all nutritional intake were maintained.

Snacks and drinks were readily available, choice was offered and facilitated, and the satisfaction of residents with the meals and snacks was monitored.

**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):**

No actions were required from the previous inspection.

**Findings:**

There were systems in place in relation to the management of medications, for example there were appropriate structures and process for the ordering, storage, administration and stock control of medications. Staff had been trained in the safe administration of medications and there were structured assessments of implementation of this training.

There was a policy on the management of medications, and some improvements had been made since the last inspection in the content of this policy, which now included guidance on the use of crushed medications.

However, the actions required from the last inspection relating to the timing of prescriptions had not been fully implemented, as further discussed under Outcome 18, nor had the action relating to the guidance of PRN (as required) medications, as discussed under Outcome 7.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

**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. For example one of the managers of the centre had a reporting relationship with two different managers, and two separate supervision processes.

The inspector was concerned that there was some confusion about the identity of the person in charge. An application had been made to the authority to replace the person in charge, and the person to whom this application referred was the senior person on duty at the commencement of the inspection, and identified themselves to the inspector as the person in charge. However this person was unaware of the responsibilities of the role under the regulations, and the inspector was concerned about their suitability to undertake the function. During the course of the inspection the current person in charge, who had not been on duty at the start of the inspection, attended and informed the inspector that the application to change the person in charge had been made to the authority in error, and that no change was being made to the role of the person in charge under the regulations.

Senior management team meetings were held regularly, and the discussions of these meetings were minuted. However meetings of local managers were held only intermittently. Monthly care planning meetings were held and again the discussions of these meetings were documented. However, this documentation did not give clear indications as to the decisions made or the actions agreed at these meetings.

There was no evidence of the annual review of the safety and quality of the service as required by Regulations, and no six monthly unannounced visits to the centre had been conducted by the provider as required by the 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.

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Since the last inspection, the inspector continued to be concerned about the staffing levels and skills mix within the designated centre. There was not always a nurse on duty, and residents in the centre had extensive healthcare needs. Where a nurse took annual leave they were not replaced, which could result in as few as 20 nursing hours in the week. There was no nurse allocated to night duty. In addition, the inspector was concerned that information given by staff members as to how they would contact a nurse if no nursing staff were on duty differed to that given by the person in charge.

The issue of staffing levels and skill mix was highlighted in the last inspection in March 2014, the agreed action was that a review of assessment of need to ensure that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents was to be conducted, followed by a roster review and any required changes to the roster. None of these actions had been completed.

Staff training had taken place in various areas, including the safe administration of medications, rescue medications in relation to epilepsy and protection of vulnerable adults. However an agreed action from the last inspections was that staff would receive training in the management of dysphagia, in line with the assessed needs of the residents, and only approximately half of the staffing complement had received this training.

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

While some improvements had been made in the policies required in Schedule 5 of the regulations since the last inspection, not all the agreed actions had been implemented,

and further improvements were required.

A policy on the management of residents' finances and a policy on the management of nutrition had been put in place since the previous inspection. Some improvements had been made in the policy on the management of medications, for example, it now included guidance to staff on the crushing of medications. However, guidance relating to the disposal of the lids of medication blister packs, which contained personal information, was still not included.

Not all prescriptions for PRN(as required) medications included the conditions under which the medication should be administered as previously outlined. In addition, while there had been some improvement in the recording of the times of administration of medications, the prescriptions still did not include times. The inspector was concerned that this could lead to inappropriate timings of medications administration.

**Judgment:**

Non Compliant - Major

**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:***

Julie Pryce  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
<b>Centre ID:</b>	OSV-0003456
<b>Date of Inspection:</b>	22 January 2015
<b>Date of response:</b>	16 March 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 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 of assessment of the effectiveness of personal plans where implementation was not recorded.

**Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in

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

circumstances and new developments.

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

A meeting will be held with each resident (and individuals of their choosing) to review each individual's personal plan by 30th June 2015. Following this, reviews will occur on a six monthly basis (or sooner if the individuals needs / preferences change). Personal care interventions required on a regular basis will be recorded in the individuals care notes to ensure evidence is in place that these interventions have occurred and if they have not, a rationale for same.

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

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

Not all residents' needs were reflected in their personal plans

**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 meeting will be held with each resident (and individuals of their choosing) to review each individual's personal plan by 30th June 2015. Following this, reviews will occur on a six monthly basis (or sooner if the individuals needs / preferences change). These plans will not only include a plan around the individuals healthcare needs but will include a comprehensive social care section outlining the individuals social care needs and preferences.

**Proposed Timescale:** 30/06/2015

**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:**

Systems for responding to emergencies were not clear

**Action Required:**

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

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

Clear protocols will be developed guiding staff in decision making in relation to the administration of rescue medication in the case of an emergency. Protocols will also be developed in relation to the administration of PRN medication. These protocols will be disseminated to all staff administering medication, along with clear guidance around how to manage this risk and who to contact should a query arise.

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

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

Fire equipment listed as missing was not accounted for.

**Action Required:**

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

A gap audit of all fire equipment will be carried out. Any necessary equipment identified as not present in the service will be sourced and purchased.

**Proposed Timescale:** 10/04/2015

## **Outcome 09: Notification of Incidents**

**Theme:** Safe Services

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

An allegation of abuse had not been notified to the Chief Inspector within three working days.

**Action Required:**

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

- a) A Heads of Department is scheduled for 16th March 2015. An agenda item for this meeting will be statutory notifications to HIQA. All staff will be reminded of the required notifications and the timeframe for submission. Staff will also be reminded to contact their line manager or the Service Quality Officer if they have any queries regarding statutory notifications. HIQA will be a recurring agenda item at each staff meeting.
- b) A laminated list of the notifications and the required timeframes, along with a copy of the guidance document will be posted in the staff room and other communal office

areas throughout the building.

**Proposed Timescale:** 16/03/2015

#### **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:**

Systems of meetings were intermittent or inadequately documented.

**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:**

Meetings between Heads of Departments will commence 9th March 2015 and be scheduled on a 4 weekly basis.

These meetings will be Service User driven (i.e based around each individual Service User) Minutes will be taken to record discussions around individual and to record all actions agreed upon, agreed timeframes and individuals responsibilities.

**Proposed Timescale:** 16/03/2015

**Theme:** Leadership, Governance and Management

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

No annual review of the quality and safety of care and support had taken place.

**Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

A comprehensive quality and safety audit was carried out in Ardeen Cheshire Home on 5th, 6th & 7th February 2013 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 Ardeen Cheshire Home).

A quality and safety audit will be carried out in Ardeen Cheshire Home in the coming months and a report will be produced by the auditor (on behalf of the Registered

Provider - who will be a member of staff external to Ardeen Cheshire Home) 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.

**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:**

The registered provider had not carried out any 6 monthly unannounced visits to the centre.

**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 comprehensive quality and safety audit was carried out in Ardeen Cheshire Home on 5th, 6th & 7th February 2013 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 Ardeen Cheshire Home).

A quality and safety audit will be carried out in Ardeen Cheshire Home in the coming months and a report will be produced by the auditor (on behalf of the Registered Provider - who will be a member of staff external to Ardeen Cheshire Home) 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.

**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:**

There was no evidence that the registered provider had ensured that the number, qualifications and skill mix of staff was appropriate to the assessed needs of the residents.

**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 assessment of need to be carried out 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. This assessment will be carried out by the Clinical Support Services Department in partnership with the Head of Care & Nursing Care Team and will be completed by 15th May 2015. A subsequent roster review will be carried out by the Service Manager & Head of Care in conjunction with the Human Resources department and any required changes to the current roster to be implemented.

**Proposed Timescale:** 15/06/2015

## Outcome 18: Records and documentation

**Theme:** Use of Information

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

Several of the policies required in Schedule 5 of the regulations were not in place.

**Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

5 policies listed in Schedule 5 have been identified as not being in place. A meeting of Cheshire Ireland's Senior Management team is scheduled to take place on 1st April 2105. Responsibility for the development of these policies will be assigned during this meeting, with achievable timeframes for development agreed upon.

**Proposed Timescale:** 30/06/2015

**Theme:** Use of Information

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

The medication policy was not sufficiently detailed as to guide practice.

**Action Required:**

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

Cheshire Irelands Clinical Support Services department to review the current medication management policy to ensure it contains sufficient detail to guide practice. Guidance regarding the disposal of lids of medication blister packs will be added to the policy.

**Proposed Timescale:** 15/04/2015

**Theme:** Use of Information

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

The records required under Schedule 3 of the regulations were incomplete.

**Action Required:**

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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 review of Schedule 3 requirements to be carried out, with a subsequent audit of the current directory of residents. Any gaps / information not currently contained in the directory to be sourced and inputted.

**Proposed Timescale:** 15/04/2015