Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003441
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake Knox
Lead inspector:	Leone Ewings
Support inspector(s):	Paul Pearson
Type of inspection	Unannounced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, 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:	To:
01 July 2015 11:00	01 July 2015 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This monitoring inspection of the designated centre was unannounced and took place over one day. This was the third inspection of this centre and the purpose was to follow up and review progress relating to the 33 non-compliances and progress made further to the most recent registration inspection which took place on 7 and 8 April 2015. As part of the inspection, inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors met with residents who were in the main complimentary of the service and supports being provided at the centre. One resident was on a holiday break at the time of the inspection.

Following the registration inspection, there were a number of areas of non-compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (children and adults) with disabilities) Regulations 2013. The governance and management systems were weak and did not support and promote the delivery of safe quality care services.

At the last inspection Outcome 17 Staffing, was rated as major non compliance, and this had not been fully addressed. Inspectors found that identified breeches of the the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013. Inspectors found that there continued to be an inadequate number of registered nurses employed to meet and supervise the assessed health care needs of the residents.

Areas of non-compliance with the Regulations followed up which were communicated to the provider with action plans and time frames agreed following the last inspection remained unchanged - they included:

- The clinical health care needs of residents, such as gastrostomy care, bowel care, catheter care were not being adequately managed to ensure the safety of residents, and completion of associated documentation and care plans
- Personal plans for all residents assessed interests, likes and goals were not in place
- Premises
- Safeguarding and safety
- Documentation of complaints and outcomes of investigations
- Provision of up-to-date mandatory training to staff
- Provision of evidence based training for all staff to meet the health care needs of residents
- The ongoing review of the safety and quality of care provided to residents and an annual review of the safety and quality of care provided to residents.

A warning letter was issued to the provider on 2 July 2015 in respect of staffing provision and governance, and he was was requested to attend a meeting in the Authority offices on the 21 July 2015 to discuss and provide assurances that the health care needs and staff skill mix in the centre was satisfactory. A detailed plan to address this non-compliance was requested as part of the requirements to be submitted to the Authority by 17 July 2015. The plan submitted to the Authority by the person in charge was not found to be detailed or specific to meet the requirements of the regulations. A more specific revised response was requested, to fully address the governance and staffing major non-compliances at a regulatory meeting which was held with the person in charge and her line manager on 21 July 2015. This revised response was submitted to the Authority on 25 July 2015 and was reviewed by the inspector and will require additional follow up and inspection to ensure that the actions by the provider are fully implemented. The Authority is also considering other regulatory actions.

The actions are outlined in the body of the report and the Action Plan at the end of the 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Residents spoken to confirmed to inspectors their ongoing satisfaction with service provision at the centre. Inspectors observed the complaints procedure on display at the entrance to the centre, and this had been updated since the last inspection. Information about advocacy services was also available in leaflet form by the front door.

The inspectors reviewed the progress relating to the action plan submitted following the inspection agreed on 8 May 2015. Aspects of the action plan inspected against had time frames agreed which will expire on 30 September 2015. However, inspectors were not satisfied that there had been sufficient progress or improvement to address outstanding documentation, and sufficient measures were not in place to ensure the effectiveness of the complaints process.

At the time of the last inspection there had been two outstanding complaints which were being addressed in a formal complaints process. The provider has now appointed the service quality officer as the national complaints officer. Complaints management training was being sourced at the time of the inspection. A time frame for completion of this training for key staff was agreed as 30 September 2015. However, progress to complete on any outstanding complaints further to the last inspection could not be fully evidenced by the person in charge and provider.

The documentation relating to two complaints reviewed by the inspectors on the last inspection was requested, as no final outcome had been available at the time of the last inspection. Records were in place to describe the issues raised and the actions of staff.

However, improvements were required and the inspectors were not satisfied that the outcome of the complaints had been fully documented in accordance with regulation. Inspectors were informed by the person in charge that she and the provider met with the complainant on 19 December 2014. However, there was no record of this meeting held in the file, and the outcome of this meeting and actions taken on the foot of the complaint had not been communicated to the complainant in line with the centre's own policy and procedure. Complaints were managed and documented in line with the complaints policy, and there was now sufficient oversight by the person nominated in the complaints process.

Judgment:
Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Inspector did not fully review this Outcome at the time of this inspection as the provider was still within the agreed time frame of 31 August 2015 to fully address the contracts of care. The person in charge reported to inspectors that progress was being made with this action plan.

Judgment:
Substantially Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

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

Findings:
Inspectors judged that the provider and person in charge had partially addressed this non-compliance. Staff training in personal planning having taken place since the last inspection. The time frames for completion were agreed as 31 August 2015. The purpose of the review was to monitor progress in this area. The improvements required relate to provision of individual personal plans, reflecting the involvement of the resident with goal setting. At the time of the inspection residents written personal plans had not been completed, but this was planned for. However, there was no written plan of how this would be achieved within the time frame previously agreed. Planning for short and long term goals, and supports in place to fully implement the arrangements agreed were not evident on this monitoring inspection.

The feedback from residents on the day of the inspection clearly reflected that varied social activity took place. While there was evidence that residents engaged in social activities such as holidays, theatre, concerts trips and meals out in restaurants. However, all residents did not have a comprehensive written personal plan completed which reflected the involvement of the resident and personal goal setting and activities undertaken.

The person in charge and service co-ordinator confirmed that all care support staff had received training in assessment and development of personal plans by the clinical support service team within the agreed time frame. However, the personal plans had not all been put in place to date, and a time frame of 31 August 2015 had been set by the provider and person in charge to complete and fully address this non-compliance. The creation and completion of accessible personal plans was discussed with staff and it was still unclear how residents involvement would be planned for by the person in charge in accordance with the requirements of regulation. Staff could not clearly communicate to inspectors what the overall plan was with implementation of the training received and how this would be monitored and evaluated.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

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

Findings:
Inspectors found that some improvements had taken place or were in progress since the last inspection. For example, the laundry space had been re-located to a more spacious room where it was more accessible for residents who wished to be involved or undertake their own clothes washing and drying. A spacious clinical room had been identified and furnished for use when the physiotherapist, occupational therapist and other professions visited the designated centre. The windows at the centre had been risk assessed and new handles were now in place.

External pathways had been reviewed and ground works were in progress on the driveway into the designated centre at the time of this inspection. However, some residents who used wheelchairs could easily use the driveway and were observed out in the gardens and front gate area with staff. The person in charge confirmed that correspondence with the appropriate authorities had been commenced, to address two pot holes near main entrance as this area was not the property of the provider. Internal painting and decorating had taken place and further work was planned for. Maintenance work was observed as ongoing in the garden of the designated centre.

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

Findings:
The provider had not fully addressed the two actions required further to the registration inspection.

Residents are requested to refrain from smoking in the centre, and that the statement of purpose outlines that a risk assessment will take place where required to reduce or eliminate all fire risks. The requirement to put in place a comprehensive written risk assessment to ensure that the risk control measures were in place for two residents who

smoked in their bedrooms, were in place in line with the smoking policy. Evidence that the action plan response had been robustly addressed by the provider was requested by inspectors, but could not be provided at the time of this inspection by the person in charge.

Most staff working at the centre had received fire safety training in the last two years. Staff knowledge of actions to take if fire alarm was activated was good. However, two staff who appeared on the current roster did not have evidence of refresher training, which was planned for according to the person in charge. Fire drills were documented for 2015 but none had taken place since the time of the last inspection on 7 and 8 April 2015. Fire drills had not taken part out of hours when staff numbers were reduced, the person in charge confirmed that plans were in place to complete planned fire drills out of hours as part of the last inspection action plan response. The centre had a fire alarm system in place, with smoke detectors and a sprinkler system in the kitchen area.

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

Findings:
The provider and person in charge had agreed that a review of restrictive practices with the service would be carried out to ensure that they had been identified and assessed, and are in line with the national policy and best practice. As the time frame for this was agreed as 31 August 2015. Recruitment of a clinical nurse manager was part of the provider response to fully address this non compliance. However, this had not taken place to date as outlined in Outcome 17.

No evidence of comprehensive review was evidenced as being in process of addressing this non-compliance. The person in charge informed inspectors that this was planned for to commence when the new documentation system commenced. The inspectors found that training and any alternatives had not been fully considered before use of any restrictive practice, and as outlined in Outcome 18 the documentation of any

assessment and / or reviews was not sufficiently evidenced in the residents' records in line with best practice.

The final investigation report was not available further to the action plan although the time frame for completion had expired. A meeting held with the person in charge and provider were not documented in the records reviewed or available for inspection.

Further to the last inspection there had been a report made relating to an allegation relating to staff misconduct. The records of interviews and follow up were reviewed by the inspectors. The overall response had been timely and the resident was supported and safeguarded through the process. The person in charge had identified that a small number of staff working at the centre had not received adult protection training commensurate with their duties and this was now planned for. The person in charge confirmed that volunteer staff had received adult protection training. The final outcome of the investigation was not available, and the person in charge could not evidence that the provider had been informed of the safeguarding allegation in a timely manner.

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

Findings:
The provider had satisfactorily submitted the relevant NF06 written notification further to the last inspection. The matters outlined in this notification had been investigated and are dealt with in Outcome 8 of this inspection report.

All other notifications have been submitted within the time frames required by legislation. However, a review of restrictive practices and risk assessments had not taken place to date as outlined in the response from the provider.

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

Findings:
Some improvements had taken place and could be evidenced since the last inspection. Training for staff involved with managing epilepsy medication was planned for and had been identified by the person in charge as required further to a serious incident notified to the Authority. The gastrostomy care plan had been updated further to the last inspection, and the practices were in line with the policy in place for management of gastrostomy. However, the date of the most recent change of gastrostomy tube had not been documented and a practices relating to the use of cooled boiled water from a water boiler were not clearly written out on the care plan to fully to inform and guide practice in this area.

Residents did not receive appropriate supervision of their healthcare to meet their assessed needs. Staff training in dysphagia, gastrostomy care and first aid had taken place. Inspectors found that the majority of clinical care such as medication, gastrostomy, bowel and catheter care was delegated on a daily basis to care support staff. Policy and procedure supported the use on non-nursing staff but clearly identified the service manager and nursing staff as required to supervise all delegated clinical care to ensure safety of care delivery.
Inspectors found that some care support staff had not received updating of their clinical skills training had not taken place over the last number of years. Competencies had not been assessed within the time lines set by the provider in the policy for all staff involved with delivering extended roles. A full training needs analysis relating to the staff supporting the clinical care needs of residents had not taken place and could be evidenced.

Competency of staff undertaking extended roles could not be evidenced fully by the provider and this was a clinical risk not being fully mitigated and a concern to inspectors. This concern relates to the identification and assessment of residents identified clinical needs, with non clinical staff carrying out healthcare assessments and providing care outside their scope of practice. For example, care support staff and volunteers accompanied residents to activities and were required to have some level of involvement with emptying the catheter urine bags. Staff delegated this clinical work had not received up to date training or updates to inform and guide their practice, and were not receiving appropriate supervision on a daily basis.

The records reviewed and the staff interviewed by inspectors did not clearly demonstrate safe practice, and staff competencies in line with the written policy, and staff knowledge of evidence based best practice. Inspectors found the overall the management of gastrostomy, bowel care, catheter care, epilepsy management required

improvement, in order to provide safe supports on a daily basis. The findings were discussed with person in charge during the feedback, who assured inspectors that appropriate action would be taken to meet the health care needs of residents.

Inspectors reviewed care plans, medication charts and care records relating to residents assessed as requiring support with bowel management. The care plans in place were not lead by nursing staff, but had been written by care support staff, and were not fully in line with best practice, or in line with the organisations policy on bowel care. Care support staff involved with administering bowel medication on a regular basis had not received the required level of training and competency reviews every two years as required by the policy. The staff had been instructed to cease using a bowel chart record for a number of residents, and had been given guidance to use the narrative to record any bowel management and results. The inspectors were not satisfied that sufficient oversight and monitoring was in place from a nursing perspective to ensure safe practice and care planning in this area.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose had been updated by the provider to include the Schedule 1 information required. However, the copy given to the inspector by the person in charge, at the close of the inspection was discussed and the actual arrangements and whole time equivalent for registered nursing staff was not accurately reflected. The person in charge agreed this required a review and she would re-submit. Staffing documented included a full time clinical nurse manager to meet the stated aims of the service, and this was not reflective of the staffing roster.

Judgment:
Substantially 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 centres' written annual review of quality and safety as required by Regulation 23, was not available for review on inspection. The provider was requested to submit this report within five working days for review. The systems in place to review the safety and quality of care provided required improvement. A number of audits had been completed since the previous inspection and included audits of medication management and care plans. However, the audits did not bring about significant change or improvement. There was no evidence of action taken or measures put in place from the audits carried out.

In view of the regulatory non-compliances and inadequate response to previous inspection and monitoring activity. A written warning letter was issued to the provider on 2 July 2015 following this inspection in respect of staffing. A meeting was requested to take place on 21 July 2015 to review progress and response due back on 17 July 2015 to major non-compliance in staffing as described in Outcome 17.

Inspectors found that the management systems in place did not ensure that services provided were safe, appropriate to residents needs, consistently and effectively monitored. The post of person in charge of the centre, was full time and met the requirements of the Regulations. The person in charge was supported by a service co-ordinator and a regional services manager who reports to the provider nominee who is the Chief Executive Officer.

Inspectors found that there was a lack of clinical governance in the centre which resulted in poor outcomes for residents. Inspectors identified non compliances in the supervision and delegation of clinical care needs as outlined in Outcome 11 (healthcare) and insufficient staffing skill mix as outlined in Outcome 17. The provider had been actively advertising and holding interviews for a clinical nurse manager to support the person in charge.

While there was deputising arrangements in the absence of the person in charge, this was not sufficient to meet the clinical needs of residents. The on-call arrangements at the weekends were provided by persons in charge for the service and other services, not all could provide clinical nursing cover. The person in charge and staff confirmed they had no emergency on call arrangements particularly when the person in charge

took annual leave, or other unanticipated leave.

Inspectors found that the provider had failed to ensure the arrangements provided sufficient oversight of key areas staffing and healthcare issues as discussed throughout this report.

The evidence of planning compliance is still outstanding and is a regulatory requirement under the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. The breaches in the regulations as clearly outlined in this and two previous inspection reports are the responsibility of the provider and the person in charge. Due to the cumulative findings and major non-compliances described in Outcome 14 and17 the centre is poorly managed.

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:
Staff files were reviewed and they contained the documents as required by Schedule 2 of Regulations. This had been an action at the previous inspection and was completed. Agency staff were now fully documented and relief shifts fully documented on the planned staff rota by the person in charge.

Inspectors found that the staff skill mix was not sufficient to fully meet and supervise the nursing needs of residents. Improvements were also required in relation to the training provided to staff to meet the assessed nursing and clinical support needs of the residents. Residents living at the designated centre had complex physical, neurological and sensory disability. The statement of purpose stated that the service is for those with 'high physical supports' and that nursing care is provided inclusive of clinical care of gastrostomy, catheter care, wound care, medication management, additionally 'training and supervision to care support workers on certain tasks relating to care of people living' at the centre would be provided.

The skill mix of staff available to meet the changing health and social care needs and supervise appropriately was not adequate at all times or in line with the statement of purpose. The person in charge is a registered nurse and works full-time at the service. An agency nurse was working at the service at the time of the previous inspection, this had ceased. The person in charge outlined the action they were taking to address this deficit, and they were in the process of recruiting a new clinical nurse manager. As outlined throughout the report, this was negatively affecting residents health care needs. The action plan response from the last inspection had identified the role the clinical nurse manager would undertake in detail to address non-compliances. Other than the recruitment of one full time clinical nurse manager, there was no evidence of any meaningful written review of staffing, staffing competencies or on-call arrangements at the centre to meet the changing health and social care needs of the residents.

Staff training records showed that mandatory training was provided to staff. However, not all staff did had completed up-to-date refresher training, for example, fire safety and moving and handling. The person in charge confirmed that dates had been identified to complete this mandatory training. Care support workers were required to make clinical decisions and provided clinical interventions when there was no nursing staff on duty, such as nights, weekends and bank holidays and some dates when the person in charge was on leave. Interventions included the administration of per rectum medication, management of gastrostomy tube, caring from residents with skin problems, at risk of pressure sores and care of residents with epilepsy. However, some risk assessments and assignments of duty were not appropriate or staff had not had their competencies to undertake this role assessed on an ongoing basis. For example, there were identified gaps of 7 years since the staff received bowel care training, and no records of competencies completed in the last two years were available.

Residents confirmed that there was a sufficient number of care support staff on duty at the weekends to meet residents' needs. Rosters showed and residents confirmed that there is an adequate number of care staff. Residents said that they felt there were sufficient staff and that staff were very supportive of their care needs.

There were four volunteers in the centre, and some volunteer staff were observed spending time with residents during the day. The volunteers also accompanied residents to appointments and social activity. However, some risk assessment and assignments were not suitably allocated. For example, a resident attended a dental appointment with a volunteer where a care support worker or nurse was necessary to meet the assessed moving and handling needs.

Judgment:
Non Compliant - Major

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:
Inspectors found the staffing rosters were not fully maintained by the person in charge and contained the houses worked by the person in charge, agency staff and service co-ordinator in line with Schedule 4. The inspector found that the records listed in schedules 2, 3 and 4 of the Regulations were maintained. However, improvements were identified in records required to be kept for residents. For example, complaints records and there were gaps in the health care information maintained for some residents; personal plans, health care plans and specific clinical care needs relating to bowel care.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. A draft admissions, transfer and discharge policy had not been finalised since the last inspection.

The gaps identified in the written directory of residents had not been fully addressed. For example, the residents home address and their date of admission to the centre. The provider has undertaken to address the input of date to the service user database by 31 July 2015.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003441
Date of Inspection:	01 July 2015
Date of response:	29 October 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 complainant was not informed promptly of the outcome of complaints in all cases with details of the appeals process.

1. Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed

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

promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
The complainant was contacted by the Provider by e-mail and invited to a second meeting to discuss the complaint. The Service Manager has contacted the complainant by letter to ascertain if the complaint is fully closed off.

Complaints are reviewed and discussed with the Eastern Regional Manager and Service Manager at supervision meetings which are held on a monthly basis. Minutes are available.
Service Manager discusses all complaints which progress to the preliminary with appointed CI National Complaints Manager (Service Quality Officer) and regional manager and seeks advice at all stages of process, including provision of information to individuals regarding outcomes of complaints raised.

A written record of all complaints are stored in the centre and on logged electronically on the organisations national database.
The electronic database has been updated to contain a section for logging satisfaction / dissatisfaction with the outcome of each complaint

Responsible Individual(s); Service Manager

Proposed Timescale: 08/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The nominated person had not ensured that all complaints were appropriately responded to and records maintained as specified in the legislation.

2. Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
All previous complaints have now been responded to and recorded.
Complaints are reviewed and discussed with the Eastern Regional Manager and Service Manager at supervision meetings which are held on a monthly basis. Minutes are available.
Service Manager discusses all complaints which progress to the preliminary with appointed CI National Complaints Manager (Service Quality Officer) and Regional Manager and seeks advice at all stages of process, including provision of information to individuals regarding outcomes of complaints raised.

A written record of all complaints are stored in the centre and on logged electronically

on the organisations national database.
The electronic database has been updated to contain a section for logging satisfaction / dissatisfaction with the outcome of each complaint

Responsible Individual(s): Service Manager

Proposed Timescale: 16/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records maintained by the nominated person were not complete and did not include the outcome of the complaint, any action taken on the foot of the complaint and whether or not the resident was satisfied.

3. 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:
The documentation pertaining to one complaint has a recorded outcome and recommendations put in place.

Complaints are reviewed and discussed with the Eastern Regional Manager and Service Manager at supervision meetings which are held on a monthly basis. Minutes are available.
Service Manager discusses all complaints which progress to the preliminary with appointed CI National Complaints Manager (Service Quality Officer) and Regional Manager and seeks advice at all stages of process, including provision of information to individuals regarding outcomes of complaints raised.

A written record of all complaints are stored in the centre and on logged electronically on the organisations national database.
The electronic database has been updated to contain a section for logging satisfaction / dissatisfaction with the outcome of each complaint

Responsible Individual(s); Service Manager

Proposed Timescale: 06/08/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of contracts of care reviewed were found not to be signed and agreed by the resident or their representative.

4. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
The contracts of care have been reviewed and now require discussion and agreement and to be signed by each resident or their representative.

Responsible Individual(s);Service Manager CNM1 & Regional Clinical Educational Facilitator

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Additional charges were not fully outlined in the contract of care, and support hours not specified.

5. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
The contracts of care in existence have been reviewed and all appropriate fees outlined and documented. These contacts of care now require discussion and agreement and to be signed by each resident or their representative.

Responsible Individual(s);Service Manager

Proposed Timescale: 31/10/2015

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:

All residents did not have a comprehensive personal plan which reflected the involvement of the resident and personal goal setting.

6. Action Required:
Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
All residents now have a comprehensive personal plan which was developed in collaboration with the resident and / or a family member or key worker. These plans contain personal goals as identified by the resident. A personal planning audit will be carried out by 30th November 2015 by the CNM1 and Service Manager. A meeting takes place every 6 weeks involving the Service Manager, Service Coordinator and Clinical Educator Facilitator to review resident's personal plans. The newly appointed CNM1 will be involved in these meeting going forward.

The CNM1 and Service Manager have developed Healthcare plans with each resident and their key worker These plans are in place in each individual's personal plan in an accessible format. An annual review of each resident by GP has taken place on Tuesday 8th September2015. Any changed healthcare needs identified will be documented and updated in individuals plans as required by CNM1. All Health plans will be reviewed by the CNM1 and the Regional Educational Facilitator at least every 6 weeks or as required.

Responsible Individual(s); CNM1, Service Coordinator & Service Manager

Proposed Timescale: 29/10/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The pathways external to the premises require review and minor repairs and replacement to allow for residents' safety.

7. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
Correspondence with the Local Authority has taken place and the potholes external to the entrance have been repaired. These potholes will be monitored regularly by maintenance staff and the Local Authority will be notified again when repairs are required

Responsible Individual (s): Service Manager, Service Coordinator & CE Supervisor.

Proposed Timescale: 08/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Driveway repairs were incomplete and work was in progress to address this matter.

8. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
CE participants (staff), in conjunction with Cheshire Ireland staff have addressed all areas of internal repairs identified as requiring replacement, renovation and /or repair or maintenance. The external pot holes identified by HIQA inspectors have been repaired. On going maintenance and repairs are discussed at Health & Safety meetings (which are held every bi monthly) and also at monthly meetings held with the Service Manager and CE Supervisor. This will ensure that the building and external pathways are aesthetically pleasing, continued upkeep is maintained, and paths remain safe and accessible for all residents.

Responsible Individual(s): Service Manager , Service Coordinator & CE Supervisor

Proposed Timescale: 08/07/2015

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:
Risks associated with two residents smoking in their own bedrooms contrary to the smoking policy had not been mitigated or documented fully.

9. 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:

Risk assessments associated with the two residents who smoke in their own bedrooms have been undertaken. In conjunction with the advice of Cheshire Irelands Health and Safety Officer, further fire safety appliances have been sourced (such as fire retardant curtain sprays, bedlinen and bedside lamps). These measures have been discussed with residents prior to purchasing them, taking into account and consideration any impact these may have on the individual's quality of life. One resident agreed to give his cigarettes to the night staff to eliminate a fire risk. In the event of a resident wishing to smoke in their bedroom, they have been advised to contact staff to ensure it is safe to do so.

Responsible Individual(s): Service Coordinator & Service Manager

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills did not take place out of hours to include residents and staff working in limited numbers.

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

Please state the actions you have taken or are planning to take:
1. Out of hours fire drills have taken place on 27th July, 3rd September, 9th September 2015
2. A regular and on-going schedule of fire drills (including out of hours fire drills) continue to take place to ensure all staff and residents are involved in this practice and aware of the procedure to be followed in the event of a fire.

Responsible Individual(s); Service Coordinator & Service Manager

Proposed Timescale: 09/09/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive practices were not fully assessed and reviewed or documented in accordance with national policy and evidence based practice.

11. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
Restrictive practices have been fully assessed and reviewed. Some residents have requested to trial low-low beds and crash mats. This type of bed has been hired from an external company and delivery is expected on 11th September 2015. Two crash mats have been delivered. . When this trial has been completed, any restrictive practices will be documented in personal plans and also documented on the Quarterly HIQA Notifications. The Service Manager will ensure that the least restrictive practice is always the preferred option for the individual (based on a risk assessment).

Responsible Individual(s): Service Coordinator & Service Manager

Proposed Timescale: 31/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The final written investigation reports for two safeguarding allegations were not completed on the date of the inspection.

12. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
The final written investigation reports for two safeguarding allegations have now been completed and signed off. The recommendations from these reports are being implemented by the Service Manager.

Responsible Individual(s):Service Manager

Proposed Timescale: 16/09/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Competency of staff undertaking extended roles could not be evidenced fully by the provider.

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

Please state the actions you have taken or are planning to take:
Each resident's health care needs have been assessed and addressed with their GP /CNM1. Appropriate referrals are made to allied health care services such as speech and language therapists, dietician and Occupational therapist.

Health care plans are in place lead by CNM1 and supports put in place where required. These health care plans will be reviewed every six months or when any changes dictates.

An agency occupational therapist has been appointed to commence employment in the service from 1st November 2015.

A nutritional workshop will take place on 4th November 2015 to guide staff in ensuring food is nutritious, appetising, varied and in line with advice from dietician and/or speech and language therapist/ dysphagia guidelines.

Each resident and /or family representative has been given an end of life booklet called 'thinking Ahead' compiled by The Irish Hospice Foundation. Personal plans will be then be developed in collaboration with the resident and/or a family representative /key worker/CNM1/ and GP taking into account their own wishes and desires,

Epilepsy training has taken place on 3rd & 15th September, 15th October and one further date scheduled for 3rd November 2015.
All care staff has received training in gastrostomy care. The gastrostomy care plan has been updated with practices in line with policy in place for management of gastrostomy to include practices relating to use of cooled boiled water to inform and guide practice in this area. The gastrostomy feed has been documented in the care plan with the advice and recommendations of dietician and is evidence based practice.
Care staff have received training in gastrostomy care will be supervised, assessed and competency signed off by CNM1.

Care staff who have received medication training and involved with catheter washouts will receive training scheduled for 11th November by external trainer. These care staff will be supervised, assessed and competencies signed off by CNM1.

Care plans relating to residents requiring support with bowel management are now in place and lead by CNM1 who has oversight and monitoring in ensuring safe practice and care planning in this area.
Care staff that have received medication training and involved with administering bowel medication are to receive training in bowel management scheduled for 13th November 2015. This will be repeated in two years as per policy. Following training staff competency will be supervised, assessed and signed off by CNM1.

Care staff and volunteers who accompany residents to activities and are involved with emptying catheter bags will be given in- service training by CMN1. Following training,

the CNM1 will carry out supervision, competencies assessed and signed off.

Records and evidence of all training, assessments and competencies sign off sheets will be kept on staff's personal files. All staff is to receive supervision by CNM1 on a daily basis.

A training needs analysis is currently underway to identify any further training gaps required following identification and assessed clinical needs of residents. This will also take place in conjunction with performance management 1:1 meetings, Service needs review, critical incidents/priority and new starters to identify performance gaps and appropriate training intervention can be put in place.

Responsible Individual(s) CNM1 & Service Manager

Proposed Timescale: 30/11/2015

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Health care plans were not in place for residents with newly identified health care needs.

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

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

Proposed Timescale:

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not state the actual whole time equivalent nursing staff employed.

15. Action Required:
Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:
The statement of purpose has been reviewed, updated and states the actual WTE of

nursing staff employed. The statement of purpose will be revised following any significant change within the service.

Responsible individual: Service Manager

Proposed Timescale: 24/10/2015

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:
The evidence of compliance with planning legislation has not been received for registration purposes.

16. Action Required:
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
All attempts/ efforts to obtain documents for the service are on-going. An external consultant has been commissioned to review the current status of the centres planning and building control requirements. They are addressing this with the Local Planning Authority.

Responsible Individual(s):Registered Provider & Service Manager

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review of quality and safety has not been made available to the inspectors.

17. 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 review of the quality, safety and support provided at the designated centre was carried out by the Service Quality Officer on 31st March 2015 and an action plan based

on this review was implemented by the Service Manager.

A review of the current quality audit system within Cheshire Ireland is underway. A working group has been appointed consisting of senior management staff and a service manager. The first meeting of this group was held on 22nd July 2015. The second meeting was held on 2nd September 2015 where a first draft of a quality and safety audit tool was developed by the group. This group will ensure that a robust structure of audit will be implemented within the organisation. A representative of the registered provider will carry out an unannounced visit by Cheshire Ireland Quality Team 30th November 2015,
Twice yearly unannounced visits will be a carried out and a report on the standard of care prepared following these visits

These visits will consist of a quality and safety audit within the centre and a report will be produced by the auditor (who will be a member of staff external to the centre) 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. An action plan will then be developed by the Service Manager and Service Coordinator (in conjunction with the Regional Manager/ Service Quality Officer and Health & Safety officer) to ensure all areas are compliant. Progress around meeting the actions required will be monitored by the Service Quality Officer/registered Provider.

A Hygiene and HACCP audit of the catering facilities has been completed by the Health and Safety Officer on 21st August & 5th September 2015. A further Buildings Health & Safety audit is due to be completed in the coming month.

A medication audit is carried out every quarter and furnished to the Clinical Educator and Facilitator. Adverse events are audited every quarter by National Risk Manager and results discussed at the centres Health and Safety meetings.

Personal plans will be audited every six months by CNM1 and Service Manager. Results will be returned to the Regional Clinical Education Facilitator for analysis and the outcomes will be returned to the service and monitored nationally. As a result of these audits, identified supports and interventions will be provided by both internal and external supports as required.

Proposed Timescale: Review to be completed by 30/ 11/ 2015 and then bi-annually
Responsible Individual(s): Service Manager, Regional Manager, Registered Provider

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in place did not ensure that services provided are safe, appropriate to residents needs, consistent and effectively monitored.

18. 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 Clinical Nurse Manager has been recruited and commenced employment on 24th August 2015 to support the current management team. This role involves supervision of care staff and delegation of clinical care needs. Also input to personal plans to include health care plan goals with resident and /or family member and key workers.
The CNM1 is liaising with the multi disciplinary team to include in house Physiotherapist and Occupational Therapist, GP, dietician and Speech and Language Therapist.

Should a resident's health status change, the CNM1 will be rostered to be available to support the resident and staff members in providing care. The CNM1 will be rostered to cover every second weekend; the Service Manager will continue to be on call on those weekends not covered by CNM1. An agency nurse is employed to cover shifts on alternate weekends/and leave.

Proposed Timescale: 24/08/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Supports and staff training and supervision were not in place for all staff to undertake delegated roles in a safely.

19. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
External trainers are and will be engaged to provide training in areas identified following any change in health needs (for example changes in care needs for individuals who have Epilepsy) The first scheduled training for all staff regarding epilepsy and seizure management took place on 3rd & 15th September , 15th October. A further date for the remaining staff is scheduled for 3rd November 2015.
A workshop on nutritional needs is scheduled for 4th November 2015

Fire safety training is scheduled for 4th November 2015
Moving and Handling training is scheduled for November 2015.
Adult protection/complaints training took place on 17th September and a date is scheduled for 18th November and every month thereafter until all staff/new staff

members have attended.
Haccap training is scheduled for November. Date to be arranged.

Other identified training required includes catheter care scheduled for 11th November and diabetes to be arranged for November (the date to be confirmed with the external trainer). Ongoing mentorship, guidance, supervision and support of care support staff is currently carried out by the Service Manager, Service Coordinator and CNMI.
Performance management is currently being rolled out to manage staff performance and support staff in the provision of services to residents. Performance Management Training has taken place last year. The Service manager has scheduled 1:1 performance review meetings with staff who report directly to her (e.g. Service Coordinator, Chef, CNM1, CE supervisor, Administrator, Maintenance Supervisor). These meetings will then take place on a 6-8 week basis. The minutes of these meetings will be recorded and agreed by both parties using a template form.
The Service Coordinator will schedule meetings with Senior care support staff; who in turn will follow the system as above. The senior care support staff will have an assigned number of care support staff who they are responsible for scheduling performance management meetings with and reviewing actions agreed every 6-8 weeks.
The CNM1 will be attending accredited professional development training session in 'insertion of suprapubic catheterisation' as soon as course dates are released. Supervision and competency sign offs for this training will be organised to take place at a nearby hospital.

Responsible Individual(s): CNM1, Service Coordinator, Service Manager

Proposed Timescale: 30/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents with assessed nursing care needs were not provided at all times due the reduction in nursing hours since the time of the last inspection.

20. Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
A CNM1 has been appointed and commenced employment on 24th August 2015 in a full time position. These nursing hours within the service will ensure that all residents with assessed nursing care needs will receive the appropriate nursing care all times. In the event of any resident requiring additional nursing hours following assessed needs/changes in health status or cover for CNM1 on leave, an agency nurse covers these shifts. An advertisement and recruitment of a fulltime RGN will take place in the

coming weeks.

Responsible Individual(s): Service Manager

Proposed Timescale: 24/08/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The skill mix of staff available to meet the changing health and social care needs and supervise appropriately was not adequate at all times or in line with the statement of purpose or application to register.

21. 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 service needs analysis was conducted by Head of Cara in October 2013 using the Northwick Park template. The information obtained from this was reviewed and a new rolling roster was devised. This ensures the staffing ratios and skill mix of staff is appropriate to the number and assessed needs of the residents
The new roster was introduced in June 2015 with agreement from staff and union representation and is on trial for 6 months. An agreed interim meeting
is due to be held by 30th September ,(date to be confirmed) with care staff on review committee, Service Manager, Service Coordinator & CNM 1

Responsible Individual(s): Service Manager, CNM1 & Service Coordinator.

Proposed Timescale: 30/11/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staffing competencies had not been reviewed to ensure that a continuous professional development programme was in place to adequately inform and guide staff in an evidence based manner.

22. 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:

Refresher training is scheduled for all senior care support staff in the areas of bowel management, medication training and catheter washouts. The CMN1 will supervise all clinical interventions and assess and sign off staff competencies in these areas of care support. These records will be kept on staff's individual's personal files.

Over the next two months the CNM1 is working with every staff member to supervise, assess and sign off competencies relating to gastrostomy tube feed and pressure ulcer management following in-service training carried out in the service for all care staff last December and earlier this year This will ensure that all care support staff have the appropriate skills to provide best practice evidence based interventions.
A training needs analysis is scheduled for October 2015 to ensure that a continuous professional development programme is implemented in the service and any further training identified will be provided to care support staff. The information gathered following supervision and performance management meetings/ or at interview stage of new staff will be documented on a spreadsheet by Service Manager and CNM1. This will identify any further training required and the results will be sent to the Learning and Development Manager

Responsible Individual(s) : CNM1 & Service Manager

Proposed Timescale: 31/10/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Appropriate supervision was not in place for care support staff.

23. 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:
The CNM1 is currently working with each staff member over the next two months to identify supervision requirements for each resident in line with best practice. An in-service training needs analysis is being currently devised with the Service manager and CNM1 to identify up-to –date training required.The information gathered following supervision and 1:1 performance management meetings with all care staff will be documented on a spreadsheet by Service Manager and CNM1.This includes any new employees This will identify any further training required and the results will be sent to the Learning and Development Manager and training will be provided accordingly.
.
All care support staff have received training in areas such as gastrostomy feed, dysphagia and ulcer prevention management between December 2014 –May 14th 2015 Further training is being rolled out for Epilepsy and seizure management. This will be carried out by an external trainer from Epilepsy Ireland. The first scheduled training was carried out on 3rd & 15th September, 15th October and one further training scheduled for 3rd November 2015.This training is required for all staff (including volunteers).

Although the current Cheshire Ireland medication management training contains a section on bowel management, most senior care staff within the service has not received up-to date training in this area as per Cheshire Irelands current policy.
In service training will be provided by the Clinical Services Support Team to the care support staff in Bowel Management scheduled for 13th November 2015
Refresher training in catheter management scheduled for 11th November 2015, diabetes training will be provided by an external Nurse Specialist by November 30th 2015.

The Service Manager in the nearby Hospital has agreed to include CI staff in refresher training in hand hygiene /cross infection/infection control when they run in-service training. Dates yet to be confirmed.

The CNM1 will carry out supervision, assessment and sign off of competencies for all care support staff following training.

A further in-service training needs analysis will take place with the CNM1 and Service Manager by 30th November 2015.This will be achieved through supervision by CNM1 and identified training requirements at 1:1 performance management meetings. The results of the information obtained will be documented on a spread sheet by the Service Manager and brought to the attention of the National Learning and Development Manager and training will be provided accordingly.
Should any new/unforeseen training needs arise e.g.; a service user develops a new care support need which requires that staff be upskilled, this will be brought to the attention of the National Learning and Development Manager and training will be provided accordingly, This will ensure that care support staff are upskilled as part of their continuous professional development .

Responsible Individual(s) National Learning and Development Manager, Head of clinical Support Services and Service Manager

Proposed Timescale: 30/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policy on admissions, transfers and discharges not finalised and was in draft format.

24. 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:
Policy and procedures on admissions, transfers and discharges has been agreed and signed off by the senior management team. This policy is now available on Cheshire Irelands website (www.cheshire.ie)

Responsible Individual(s): Service Quality Officer

Proposed Timescale: 15/09/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Directory of residents has not been updated in full as specified by the Regulations.

25. 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:
The current directory of residents has been updated with the information available to date. Efforts are being made to gather information such as resident's previous addresses and dates prior to admission to the service. This is being done by contacting family members

Responsible Individual(s): Service Manager

Proposed Timescale: 31/10/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Complaints records incomplete and not fully maintained with actions taken by provider in respect of any such complaint.

26. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
Complaint records are complete and maintained with actions
All complaints are maintained in hard copy within the service and logged electronically

on Cheshire Irelands national database. These complaints are discussed between the Regional Manager and Service Manager at monthly supervision meetings, recorded and available in the service

Individual (s) Responsible: Service Manager

Proposed Timescale: 16/09/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Clinical care plans not updated in line with Schedule 3 requirements to include a record of nursing care or other interventions.

27. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
Clinical care plans have been updated to include a record of nursing care and other interventions. These plans will continue to be updated as and when required (for example when changes occur to individual's health status.)

Responsible Individual(s) : CNM1 and Service Manager

Proposed Timescale: 15/09/2015