**Health Information and Quality Authority Regulation Directorate**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003444</td>
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<tr>
<td>Centre county:</td>
<td>Co. Dublin</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider:</td>
<td>The Cheshire Foundation in Ireland</td>
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<td>Provider Nominee:</td>
<td>Mark Blake-Knox</td>
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<td>Lead inspector:</td>
<td>Deirdre Byrne</td>
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<td>Support inspector(s):</td>
<td>Anna Doyle; Gearoid Harrahill</td>
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<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>12</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>3</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 27 October 2015 08:00  
To: 27 October 2015 21:00

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

| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 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 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

Summary of findings from this inspection

The inspection took place 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 of Residential Services for Children and Adults with Disabilities. Inspectors also followed up on areas of non compliance identified at the previous inspection, which had taken place to inform a registration decision on 16 and 17 June 2015. At that inspection, a significant number of non compliances were identified, with 37 actions required. The high level of non compliances were discussed with the provider nominee at a meeting in the Authority offices following the inspection.

As part of this inspection, inspectors met with residents and staff members, observed practices and reviewed documentation such as personal plans, accident logs, policies and procedures. At the time of the inspection, 12 residents resided in the designated centre which was a one storey building in the community in a busy urban area. There are plans in place for the centre to be de-congregated in line with national policy by December 2016.
At this inspection, inspectors found good progress had been made in addressing the non compliances from the previous inspection. The clinical governance arrangements in the centre had improved. A nurse had been working in the centre since July 2015 and a new clinical nurse manager had been recently been appointed to work in the centre full time. There were improved practices to meet the resident identified health care needs. The inspectors found improved practices in the management of complaints and an accessible user friendly procedure was available in the centre. There were improved practices in the provision of staff training in areas such as fire safety and infection control.

Staff were observed to treat the residents in a patient, respectful and friendly manner, and were knowledgeable of their social and health care needs. There was good access to medical, pharmaceutical and a range of allied health professionals, and where requested by residents, this was facilitated. There were adequate staff skill mix and numbers in place.

However, ongoing improvements were identified, these were in relation to the consultation with residents around the planned transition into the community. The roles of the new nurse manager, the person in charge and assistant manager regarding the reporting and supervision responsibilities.

The management of risk and fire safety also required improvement. Inspectors found the development and review of residents personal plans, and the monitoring of the quality of care provided in the centre required improvement.

from the 37 actions from the previous inspection, 27 actions were completed, nine were not addressed and one was in progress.

These and all other matters are outlined in the report and 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:
Inspectors found that resident’s rights and dignity was maintained, and systems were in place to allow the resident’s an opportunity to contribute to how the centre was run. However, an area of improvement was identified in relation to the consultation with residents around the decongregation plans for the centre.

There was evidence of consultation with residents. There had been one centre meeting since the last inspection and the minutes of this meeting were read. However, it did not include the planned closure or residents feedback to residents updating them on the transition from the centre. Inspectors spoke to a number of residents about the planned closure. Some were unsure of their future accommodation plans, and voiced their concerns about where they may live. The person in charge informed inspectors there were ongoing conversations with residents regarding the residents concerns, and inspectors met the two community transition coordinators assigned to support residents in their transition. The coordinators outlined the meetings and on-going consultation held with residents. However, these meetings were not clearly documented to identify the action to be taken to allay residents individual fears about the planned closure. This had been an action from the previous inspection and was not fully addressed.

The provider and person in charge did ensure residents were educated and informed about the future and living in the wider community. Up to 16 meetings had been held with the residents in the centre, with talks from external persons on a range of topics such as managing finances, food hygiene and nutrition. These meetings confirmed residents who had attended them. Since the previous inspection, two residents had moved out of the centre into their own homes in the community. One former resident
given a talk in the centre on their experiences of the move and living in the community. The community transition coordinators also met the residents on a daily basis, and supported residents to learn new skills such as baking and cooking classes. The residents who spoke to inspectors were familiar with their coordinator they were assigned to. This is discussed further in Outcome 4.

Inspectors found systems were in place for the management of complaints. The actions from the previous inspection were completed, and the policy and procedure in place was centre specific and met the requirements of the Regulations. An accessible version of the complaints procedure was prominently displayed in the centre, and an audio version was also available for residents. The person in charge informed inspectors a number of residents and some relatives had accessed it. A new form was now used to document complaints. There were two complaints since the last inspection. The records read confirmed an appropriate and timely response had been made along with feedback to the complainant.

There was access to an advocacy service and information about the residents’ rights. The person in charge outlined the services available to the residents and their families. A representative from one of the services had visited the centre to meet the residents.

Inspectors observed residents being treated by staff in a respectful and dignified manner. While the residents were very independent, they had a moderate to severe physical disability, and intimate care plans were in place to protect residents and guide staff.

The policies in place for the management of residents’ personal finances had been reviewed at the previous inspection and the procedures and practices on the handling of residents’ personal monies were found to be compliant.

There was adequate storage space for residents' personal possessions including clothes, and a laundry room to wash and dry residents clothing.

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):  
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Inspectors were satisfied that polices were in place on the admission and discharge of residents and that each resident had a contract in written format that outlined the services, facilities and fees charged by the provider.

There were policies and procedures in place for the admission, transfer and discharge of residents to the centre. The Authority had been informed the centre was to close by December 2016 and a de-congregation plan was in place. The admissions policy and the Statement of Purpose reflected this policy, and no new admissions were to be made to the centre. This was an action from the previous inspection and was addressed.

A transition team oversaw the decongregation plan of the centre. The team was headed by the person in charge and included the two community transition coordinators and a housing manager. Their role was to work with residents to identify suitable accommodation for their assessed needs and develop a package around staff support on a weekly basis. As reported earlier, two residents had moved into the community with apparent success. There was a transition plan developed for these residents and ongoing support continued after their move with meetings held with them and their support staff. However, as reported in Outcome 1, there was no documented evidence of the action and plans in place arising from these meetings, especially for residents who have reported concerns around the move.

Each resident had a written contract of care in place which laid out the terms and conditions the service provided. It was dated and signed by the resident or their representative where required. The fee was included, and the services to be provided were now added into the contract.

Judgment:
Compliant

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.
**Findings:**
Inspectors found there were personal plans in place for each resident, and there access to opportunities to participate in meaningful activities appropriate to residents interests. However, improvements were identified in the completion, review and involvement of residents in their personal plans. The actions from the previous inspection were not fully completed.

Overall, the residents’ welfare and wellbeing was maintained by a good standard of care and support by staff who were familiar with their social care needs. The residents were assessed as having a moderate to severe physical disability. Inspectors read a sample of resident residents’ personal plans, which confirmed all residents social goals had been identified. However, the development of residents personal plans required improvement. For example, there was no comprehensive assessment of residents' needs completed to inform residents emotional and support needs. Furthermore, there was no evidence if residents had been consulted with in the development of their personal plan.

A nurse recruited to the centre since the last inspection had reviewed and developed the outstanding personal plans. Each resident was assigned to a key worker assigned and a transition community worker, however, there was no evidence in their involvement in the completion of their personal plans.

The personal plans read were holistic and focused on the residents likes, interests and desires for their future. For example, one residents goals included going on holiday, attending a vintage care rally and volunteering. There were reviews completed against these goals however, it could not be ascertained how effective these goals were was or if they had been accomplished. In addition, the residents were not provided with copies of their personal plans in an accessible format.

The personal plans were completed annually and reviewed once a year however, there was no multidisciplinary input into the review of residents plans. All of these matters were discussed with the person in charge at feedback at the end of the inspection, who acknowledged improvement was required.

Inspectors found staff required additional training in the development of personal plans as evidenced in the findings above.

Inspectors reviewed a sample of residents’ care plans for their assessed needs. In general there were care plans were in place and guided the care to be delivered. However, health care plans were not developed for all residents identified needs as outlined in Outcome 11 (health care). Furthermore, intimate care plans did not consistently contain sufficient information to guide staff.

The staff were observed to interact closely with the residents, and facilitated activities during the inspection. Residents led very independent lives, with many going out to a day services placement, employment and went on outings on their own during the day. There were planned activities that took place in the centre. These were facilitated by an activities coordinator who was on leave at the time of the inspection however, staff were trained up to facilitate activities in her absence.
Activities included trips to the library, baking classes, board games, reading. In addition, outings took place from the centre for example, to shows, events, plays. Some residents were facilitated and supported to go on holidays, and inspectors spoke to two resident who had recently been on a holiday abroad.

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:
The designated centre is located on its own extensive grounds, in an urban setting and in close proximity to the local community and the city centre. In the past it accommodated up to 20 residents. There are plans to de-commission and vacate the premises by December 2016, and presently 12 residents reside in the centre. Inspectors found aspects of the design and layout of the centre did not fully meet the requirements of the Regulations.

The actions from the previous inspection were followed up and many were addressed. Old carpets had been removed, the centre had been recently painted and repair works were carried out. However, on going refurbishment and maintenance in the upkeep of the centre is required as parts of the centre were not in good repair for example, door architraves and wood hand rails in areas were chipped.

Inspectors followed up on the location of the offices in former bedrooms alongside residents bedrooms. Since the last inspection, the person in charge met with the residents in these areas. Residents were happy for the offices to remain where they were. Inspectors were placed in a office opposite residents bedroom and also met one resident who was not dissatisfied having an office close by their room. Inspectors did not observe excessive noise levels from other staff working in these rooms during the inspection.

A garden area skirts the perimeter of the building. There is a paved areas that residents can access directly accessible from the centre. Inspectors walked around the area and noted it was pleasantly landscaped with shrubbery and flowers. However, an action
regarding the pavement has not been addressed since the last inspection. Parts of the pavement were in bad repair, therefore it posed a risk to residents who required assistance mobilizing or using a wheelchair. This is discussed under Outcome 7 (risk management).

The bedrooms were all single occupancy. A number of residents rooms were visited with residents permission. The residents had added many personal belongings, and they were pleasantly decorated to their own taste. Five bedrooms in an extension to the back of the centre were provided with en-suite facilities. Each bedroom was provided with suitable storage.

There were an adequate number of toilets, showers and assisted baths provided. In addition, there were staff offices, a large catering kitchen, dining room, sitting rooms, meeting rooms, laundry, cleaning store room, sluice room.

There was specialised equipment provided. Inspectors read service reports that confirmed all assistive and specialised equipment was maintained in good working order. The provider showed inspectors a check carried out of the assistive equipment. This was an action from the previous inspection and was addressed.

The infection control procedures in place were reviewed by inspectors. Procedures to clean specialised equipment such as nebulisers were discussed with staff which appeared to be in line with evidence based practice. Since the last inspection, 21 staff had completed infection control training.

Judgment:
Substantially Compliant

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

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

**Theme:**
Effective Services

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

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

**Findings:**

Inspectors found there were systems to ensure the health and safety of residents, staff and visitors to the designated centre. However, there were improvements required in relation to aspects of fire safety and the management of risk.

Inspectors found there were systems in place to prevent the spread of fire. However, aspects of fire safety arrangements in the centre required review. Each resident had an individual personal emergency evacuation plan (PEEP) on their file. However, a sample
of PEEPs reviewed were not accurate and did not reflect residents most up to date needs. For example, impaired vision and mobility issues. There was a partially blocked fire exit in one residents bedroom which to prevent their pet from running away, while the residents and staff outlined the alternative arrangements to inspectors, these were not reflected in the residents PEEP.

The fire exits in the centre were unobstructed and records read confirmed these were checked by staff. Fire evacuation procedures were displayed throughout the centre. There were arrangements in place to service fire equipment. Records were read that confirmed that regular servicing took place along with the fire alarms and emergency lighting. This was an action from the previous inspection and was addressed.

The systems to contain fire in the centre were reviewed. However, intumescent strips on two fire doors were painted over. This would make these doors ineffective in the event of a fire. The person in charge assured inspectors at the feedback that this would be addressed. Since the last inspection, inspectors were advised a fire audit had been carried out, the person in charge was advised to submit the reports findings to the Authority on its completion.

Records read confirmed all staff completed fire training and the action from the previous inspection had been addressed. Inspectors observed fire safety training taking place in the centre during the inspection. However, staff on work placement had yet to complete fire safety training. Information received after the inspection confirmed this would be addressed and training was arranged for these persons.

There were regular fire drills, and a night time drill had also been completed. The records of these were read and they included the outcome and any areas of improvement required. The staff spoken with were familiar with the procedures to follow if the fire alarm went off.

The identification and assessment of risk in the centre required improvement. A risk management policy was in place that met the requirements of the Regulations. However, it was not fully implemented in practice, as areas of risk were identified in the centre, such as the entrance to the building was accessible to any person, unlocked rooms storing chemicals and a stream running alongside the garden. Furthermore, inspectors had raised the risk with the entrance at the previous inspection and it was still not addressed.

While staff completed individual risk assessment for residents, risk assessments had not been completed for the environment and the work place. These issues had not been identified by a health and safety audit or checks carried out in the centre. A draft risk register was shown to inspectors however which it was envisaged would capture all risks in the centre.

The systems in place to manage adverse events were reviewed. A range of incidents occurred in the centre including medication errors, falls and, choking incidents. A sample of incident forms were reviewed. A summary sheet of incidents was also read, that included a brief description of each incident and the action taken. Inspectors were told the incidents were reviewed at a health and safety committee meeting. However,
there was no analysis and trending of the data for improvement and learning and to prevent their recurrence.

A health and safety statement was seen by inspectors. There was an emergency plan in place, which included the alternative accommodation options in the event of an evacuation.

As reported in Outcome 6 there was a policy on the prevention and control of infection was read by inspectors. There were hand gels present throughout all units in the centre and hand-washing guidelines were displayed for staff.

Judgment:
Non Compliant - Moderate

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**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:**

Inspectors found there were measures in place to safeguard of residents and protect them from the risk of abuse. An area of improvement was identified regarding the assessment of restrictive practices.

There were systems in place for the management of restrictive practices. At the previous inspection, the policy on restrictive practices was reviewed and it reflected the National Policy "Towards a Restraint Free Environment". There were a three residents who used bedrails and five residents required lap belts in the centre. Some residents chose to have bedrails however, some had them in place to prevent a risk of falls. There was evidence of consultation with residents and care plans were developed to guide staff when they were in use. There was evidence of regular checks carried out. However, the assessment tool for bedrails and lap belts did not include the risks associated with entrapment. This was an action at the previous inspection and was not fully addressed.

All staff spoken to were knowledgeable in the area of protection from abuse. There was a training programme in place for staff, and records read confirmed staff had completed
up-to-date training in safeguarding of vulnerable adults. However, the staff on work placement had not completed training. This was discussed with the person in charge and assistant manager during the inspection. The assistant manager said she met individually with these staff and went through basic safeguarding information. Inspectors was later informed these staff would be scheduled to attend formal training. See Outcome 17 (workforce).

An allegation of abuse was notified to the Authority following the inspection. The policy on safeguarding vulnerable adults had been reviewed at the previous inspection and guided practice. The person in charge and manager had a satisfactory understanding of the procedures to follow to carry out an investigation. Any suspicions or allegations of abuse were also reported to the regional manager and the designated person who is the quality service manager of the organisation. The person in charge was aware of the requirement to submit the investigation report to the Authority on its completion.

Inspectors read intimate care plans that had been developed for each resident, however, they did not consistently guide the care to be delivered in line with the residents assessed needs. This is discussed in Outcome 5 (Social Care).

As with the previous inspection, there were no residents with responsive behaviours in the centre.

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:
Inspectors found that there had been significant improvements in healthcare provision since the previous inspection. However, improvements in the completion of documentation and availability of information on residents files required improvement, these are actioned in Outcomes 5 (Social care), 14 (Governance) and 18 (Records).

Since the last inspection, the provider had invested significant resources to enable improvements in relation to meeting residents' health care needs. A nurse had been employed since the last inspection, and a new clinical nurse manager (CNM) had commenced in her role on the 19 October 2015. Inspectors met both nurses during the inspection. The CNM was receiving induction training and a formal handover was being
arranged with the nurse.

The nurse had fully reviewed six of the 12 residents health care plans. She had completed a range of clinical and nursing risk assessments using a range of evidence based tools. Generally care plans were developed for residents identified needs. However, some deficits were identified and care plans were not developed for all residents. For example, mental health, hyperthyroidism and epilepsy. This is actioned under Outcome 5.

Residents had access to a General Practitioner (GP) of their choice, and there was evidence of regular reviews and visits recorded on their files. Residents had access to allied health services as required such as optician, chiropody, dietician and speech and language therapy.

Inspectors reviewed records and procedures in the area of catheter care, wound care, status epilepticus and falls management and were satisfied with the practices in place. There were improved practices in the management of residents nutritional needs. Since the last inspection, residents weights were now being taken on a monthly basis. However, records for one resident stated they were last weighed in July 2015, and there was no reason why none were taken since. Furthermore it was not clear who was delegated or responsible for taking weights in the centre.

The systems in place for the management of diabetes were reviewed. Two residents had diabetes that required regular checks, and care plans were developed for their care. Residents were also under the care of a diabetes clinic and regularly attended appointments. The staff completed blood sugar level checks twice a day before meals. However, the records read did not include a date or time of check. This could pose a risk if reviewing the information for any trends or recurrent issues. The deficits in documentation outlined in the above two paragraphs is actioned in Outcome 18.

There were good practices in place for residents to make healthy living choices around food. The meal were prepared in the catering kitchen of the centre. The residents would come to the main dining room for their meals and the menu which was displayed was updated each day. The residents breakfast was a buffet style and residents could choose anytime to attend, kitchen staff informed inspectors they could make residents a hot breakfast if they wished also. There was an area in the dining room where residents could prepare hot drinks or snacks. There was fresh fruit, and biscuits or cakes left out in between meals. Inspectors did not observe mealtimes however, they were assured by the person in charge that where residents were assisted during their meals, staff would do so in a dignified manner and sat alongside residents. This was an action at the previous inspection. It will be reviewed again at future inspections.

Inspectors met the kitchen staff on duty, who described the range of meals provided to residents. The staff were knowledgeable of residents identified special dietary requirements. There was up-to-date documented information on the residents needs were read, this was an action from the previous inspection and addressed.

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

Findings:
There policies in place to protect residents in relation to medication management were not comprehensive to guide practice and improvements were required.

The medication management policy was reviewed. It was not sufficiently comprehensive to guide staff practice. For example, there was no policy on the use of PRN (as required medication). Furthermore, the procedures for transcribing and self administration of medications were not fully implemented in practice. This was an action from the previous inspection and was still not addressed. Inspectors were informed it was currently being reviewed and would be rolled out organisation wide in six weeks.

The procedures in place for staff in relation to the transcribing were not implemented in practice or in line with professional guidelines. Inspectors read records of transcribed medications which were completed by nursing staff. However, they were not signed or dated, and a second staff did not counter sign it. Furthermore it was not clear if the GP had signed within the policy timeframe. This was an action from the previous inspection and was not competed.

Improvements were required in the procedures for self-administration of medication. Two residents self-administered with support and assistance provided by staff. However, the risk assessment process was not robust and did not ensure risks were assessed and managed. For example, one residents had reported they were uncertain about self administering medications and due to impaired vision had difficulty reading. These matters had not been considered as part of the assessment process. This was also an action from previous inspections and was not addressed.

A sample of administration and prescription sheets were read by inspectors. Overall good practices in line with professional guidelines were identified. However, the administration of as required medications were not prescribed with the maximum dosage to be administered in a 24 hour period. This is discussed in Outcome 18 (records).

There were systems in place to record incidents of medication errors. Since the last inspection in June 2015, there had been 13 medication errors. There was no evidence if
the residents needed to be reviewed by the GP or if there was any negative outcome for the resident. There was no evidence of shared learning with staff to reduce the risk of future errors. See Outcome 7 (Risk management). This was also an action from the previous inspection and required improvement.

Inspectors found medication audits were completed on a quarterly basis. A recent medication audit from September 2015 was read. However, the audits did not identify the issues reported above. See outcome 14 (Governance and Management).

There was a training programme carried out in the administration of medication, and only staff that completed training administered resident’s medications. There was training carried out with more frequency and all staff except three had completed or were in the process of completing the training.

**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:**
Inspectors found that the Statement of Purpose met the requirements of the Regulations. The actions from the previous inspection were addressed.

The Statement of Purpose accurately described the type of service and the facilities provided to the residents. It reflected the centre’s aims, ethos and facilities. It also described the care and support needs that the centre is designed to meet, as well as how those needs would be met.

**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:**
Inspectors found there was a clearly defined management structure that outlined the lines of authority and accountability in the centre. However, the documentation of meetings in the centre and systems in place to review the quality and safety of life of residents required improvement.

The centre was managed by a suitably qualified and experienced person with accountably and responsibility for the service. The person in charge demonstrated adequate knowledge of the Regulations, and was aware of his requirements therein. Inspectors found the person in charge was familiar with the residents’ social care needs, and was observed interacting with residents during the inspection. The residents in turn were very familiar with him and told inspectors that he was always available to them. The person in charge had completed training in mandatory areas.

The provider had ensured there were adequate governance arrangements in place. The person in charge was based full time in centre and reported to the provider nominee. A regional manager and service quality manager along with the provider nominee formed part of a senior management team. The person in charge met the regional manager on a regular basis. As reported earlier, an agency nurse had been recruited to work full time in the centre and a CNM had been recently recruited who would replace the nurse. Inspectors met both staff, who were present during the inspection. However, the role of the new clinical nurse manager, the person in charge and the assistant manager was not clearly defined in terms of reporting arrangement and supervision of staff. This was discussed at the feedback with the person in charge who assured inspectors this would be clarified.

While there were systems in place for the management of the centre, improvements were required. There were a number of staff meetings held and the minutes of these were provided to inspectors. However, the minutes read lacked detail and it not be ascertained what was discussed, and who was responsible for following up on matters raised at the meeting. There were no nurse meetings held to review clinical risk in the centre. Overall, inspectors could not find what clinical reviews had taken place or how decisions were made in relation to the on-going review of the residents and clinical issues, risks and supervision of residents in the centre.

There were systems in place to monitor the quality and safety of care. Inspectors reviewed audits in health and safety, fire safety and medication which had last been
carried out since the previous inspection. However, there was lack of evidence of what improvements had been brought about or action to be taken in the audits read, and issues identified during the inspection had not been identified by the audits.

There had been no unannounced provider visits since the last inspection. The person in charge outlined the new procedures for the unannounced visits. The quality officer, health and safety officer and the head of clinical services would undertake the audit together during the visit. The next visit was expected to take place in December 2015.

The provider had not developed an annual report on the overall review of the safety and quality of care of residents as required by the Regulations. Inspectors were informed that this was work in progress, and was anticipated to be completed following the next unannounced provider visit. The person in charge and provider were aware of the responsibility to consult with residents and families in the development of an annual review.

Judgment:
Non Compliant - Moderate

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:
Inspectors found there was an adequate staff skill mix and number in the centre, that met the assessed needs of residents. However, the provision of mandatory for staff required improvement.

Staff and management reported they were satisfied with number of staff in the centre. The roster reviewed confirmed the current number and skill mix of nurses and healthcare assistants was sufficient to fulfil the needs of the residents. There was a planned and actual roster read by inspectors. However, the roster did not include the days and times the person in charge, assistant manager and clinical nurse manager were on duty. See outcome 18. This was discussed with the person in charge during the inspection.
Staff had all completed the required mandatory training since the previous inspection. Records of training read confirmed all staff had completed refresher training in fire safety and prevention of abuse. However, a number of staff who had not yet received refresher in these areas as reported in Outcome 7 and 8. The staff on work placement had not completed formal fire safety and training in the prevention of abuse. Information submitted the Authority following the inspection confirmed this would be addressed by the 6 November 2015. A new induction checklist was also forwarded to the Authority which would ensure these persons would have this training prioritised as part of their induction.

Inspectors saw records of other training completed by staff such as medication management, movement and handling and infection control. However, there were some gaps in the provision of medication and movement and handling training for all staff.

Staff were observed as friendly, respectful towards the residents. When spoken to, staff were knowledgeable of the residents and their circumstances around living in the centre and their wishes for transitioning.

As reported earlier, the provider has recently recruited a new CNM who was a registered intellectual disability nurse and an agency registered general nurse had been working in the centre on fixed term contract. This was an improvement from previous inspections and ensured adequate clinical supervision of the residents and staff in the centre.

There were systems in place to supervise staff. There were regular one to one supervision meetings with staff carried out and appraisals on an annual basis.

A number of staff were employed through an agency. Inspectors reviewed a detailed service level agreement for their agency staff.

Inspectors also reviewed a detailed volunteer policy. There were currently no volunteers working in the centre.

**Judgment:**
Substantially Compliant

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**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 that there were systems in place to maintain complete and accurate records and the required policies were in place. However, there were areas of improvement identified.

Inspectors found there were records maintained for each resident. There was full and complete information included on residents files. However, there were gaps in some records required as read by inspectors. For example, blood sugar levels records did not consistently include a date or time of check. In addition, the maximum dosage of as required (PRN) medication to be administered in a 24 hour period was not stated. This had been an issue at the previous inspection and required improvement.

A directory of residents was reviewed, it was in electronic format. The information required to be maintained for each resident as per Schedule 3 of the Regulations was all included.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003444</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>27 October 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26 November 2015</td>
</tr>
</tbody>
</table>

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 process of consultation around residents fears of transitioning into the community required improvement.

1. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
• Records of transition meetings with individual service users have been amended to include what was discussed and any actions required 04/10/2015.
• Quarterly newsletter to keep service users and families informed has been developed and the first edition is to be distributed in December 2015.
• Monthly meetings re transition have recommenced with service users including updates on closure and transition progress 25/11/2015

Person/s Responsible:
Service Manager- Assistant Manager-Community Transition Coordinators

Proposed Timescale: 30/12/2015

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
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</tbody>
</table>

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessment of residents social and personal needs was not undertaken.

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

Please state the actions you have taken or are planning to take:
• A comprehensive assessment of all service user health personal and social care needs has been commenced and will be complete by December 18th 2015

Person/s Responsible
Service Manager – Assistant Manager – CNM1 – Senior Care Workers

Proposed Timescale: 18/12/2015

<table>
<thead>
<tr>
<th>Theme: Effective Services</th>
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</thead>
</table>

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not in an accessible format for residents.

3. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their
Please state the actions you have taken or are planning to take:
- To date we have identified 2 service users who require their personal plans to be in a more accessible format.
- We are working with the service users on a range of approaches including pictorial plans and audio versions.
- Keyworkers/Senior Care workers will read through personal plans with individual service users to ensure their understanding and agreement by 30/12/2015

Person/s Responsible
Service Manager – Assistant Manager – CNM1 – Senior Care Workers - Keyworkers

**Proposed Timescale:** 30/12/2015

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review of resident's personal plan did not assess their effectiveness.

4. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
- We have commenced a review of personal plans with 6 now complete.
- All personal plans will be reviewed by 31/1/2016
- Any changes in the needs or circumstances of individual service users will be recorded and reviewed by the CNM1.
- Personal plans will be reviewed on a six monthly basis or earlier if individual circumstances change.

Person/s Responsible
Service Manager – Assistant Manager – Clinical Education Facilitator – Clinical Nurse Manager 1

**Proposed Timescale:** 31/01/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Parts of the centre were not in good repair for example, door architraves and wood hand rails in areas were chipped.
5. **Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
- We have commenced a planned program of refurbishment to include sanding and varnishing of woodwork and repainting where required.
- This work will be completed by 30/12/2015

Person/s Responsible
Service Manager – Assistant Manager

**Proposed Timescale:** 30/12/2015

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**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:**
Some areas of risk had been not identified or assessed for example, the entrance, unlocked sluice rooms.

6. **Action Required:**
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
- We have reviewed the security and safety of the entrance area following a risk assessment on 10/11/2105.
- Internal doors are now locked whilst we source alternative opening mechanism suitable for all persons.
- Both sluice rooms have been fixed with keypad locks. 25/11/2015

Person/s Responsible
Service Manager – Assistant Manager

**Proposed Timescale:** 30/12/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The systems in place to control and monitor risk in the centre requires improvement.
### 7. 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:**
- The PEEPs of all service users have been reviewed to ensure appropriate arrangements have been made for their evacuation if necessary.
- It has been arranged for fire safety officer to attend a week long QQI Level 5 training course in Health & Safety Risk Management commencing November 30th 2015.
- The storage of chemicals has been addressed and all chemicals are now securely locked at all times.
- Risk issues are addressed at regular health and safety meetings and a risk log has been developed to track incidents of risk and actions required to address same.
- The risk log will be reviewed by the Service Manager on a bimonthly basis to identify any trends.
- The annual audit schedule to be completed by 30/12/2015 will include a comprehensive assessment of risk in the building and outside areas and will be conducted with the assistance of the National Health and Safety Officer.

Person/s Responsible
Service Manager – Assistant Manager – National Health and Safety Officer – Service Quality Officer

**Proposed Timescale:** 30/12/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of adverse events in the centre requires improvement.

### 8. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
- We have developed a risk log as per the previous action. All adverse incidents are monitored and will be recorded and discussed as a standing item on the agenda of the health and safety meeting.
- Adverse incidents will be reviewed on a monthly basis to identify any learning and to ensure appropriate actions are recorded.

Person/s Responsible
Service Manager – Assistant Manager – Health and Safety Officer – Service Quality Officer
**Proposed Timescale:** 10/12/2015  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Residents individual evacuation plans did not fully guide practice.

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

**Please state the actions you have taken or are planning to take:**  
- The PEEPs of all service users have been reviewed and updated as identified in our most recent inspection  
- Individual plans now guide practice and will be reviewed on a six monthly basis or sooner as required.

Person/s Responsible  
Service Manager – Assistant Manager – Senior Care Workers

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**Proposed Timescale:** 04/12/2015  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Two fire doors not maintained to a good working standard.

10. **Action Required:**  
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**  
- We have ordered new intumescent strips to replace those identified in the report. We anticipate that these will be in place by 04/12/2105  
- We will monitor the effectiveness of all fire doors on a monthly basis.

Person/s Responsible  
Service Manager – Assistant Manager

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**Proposed Timescale:** 04/12/2015  
**Theme:** Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were deficits in fire safety training for all staff.

11. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
• We have reviewed the requirement of fire safety training for all staff and participants on community placements.
• 5 staff received fire safety training on 27/11/2015
• We are implementing an updated training program for existing staff and have included this training as part of induction for all future placements

Person/s Responsible
Service Manager – Assistant Manager – Health & Safety Officer – Health & Safety Representative

Proposed Timescale: 30/12/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assessment of restrictive practices was not fully in line with the National Policy.

12. 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:
• We have reviewed the assessment tool for bed rails and lap belts to ensure it included the risks associated with entrapment.
• This has been completed 23/11/2015

Person/s Responsible
Service Manager – Assistant Manager – Clinical Education Facilitator

Proposed Timescale: 23/11/2015
## Outcome 12. Medication Management

**Theme:** Health and Development

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

The process of transcribing prescriptions was not carried in accordance with professional guidelines and the centres policy.

The administration of prescribed "as required" (PRN) medications required improvement.

### 13. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

- We have introduced a new medication Kardex which identifies maximum dosage of PRN medication within a 24 hour period. Completed.
- We have made arrangements with the relevant GP’s to update the individual Kardexs – to date 6 have been completed and we will have updated and signed off the rest by 27/11/2015
- The process of transcribing will not be carried out in the service until a more robust policy is in place.
- An organisational review of medication management policy will be completed by and implemented by end of December 2015.

Person/s Responsible

Service Manager – Assistant Manager- CNM1

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### Proposed Timescale: 30/12/2015

**Theme:** Health and Development

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

The system of self administration in the centre required improvement.

### 14. Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

- We have reviewed the self administration of medications with the 2 service users who
self-medicate and are completing a new risk assessment for each individual 4/12/2015
• If further assessment is required this will be referred to the individual GP for sign off
or any further referral required.

Person/s Responsible
Service Manager – Assistant Manager - CNM1

**Proposed Timescale:** 30/12/2015

### 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 systems in place to review the safety and quality of care required review to ensure the actions to be taken were clearly identified.

**15. 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:**
• All reviews of safety and quality will now include an appropriate action plan with clear accountability for actions required.

Person/s Responsible
Service Manager – Assistant Manager – Service Quality Officer

**Proposed Timescale:** 30/12/2015

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The roles and responsibilities of the person in charge, assistant manager and the clinical nurse manager were not clearly defined or outlined.

**16. Action Required:**
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
• The management team now meet on a two weekly basis and have further defined roles and responsibilities for each team member. 20/11/2015
• A care staff meeting has been arranged for 27/11/2015 to further clarify roles and reporting arrangements and responsibilities of all members of the management team.
• Written roles and responsibilities will be agreed and implemented by 30/12/2015

Person/s Responsible
Service Manager – Assistant Manager – CNM1 – Senior Care Workers – Community Transition Coordinators

**Proposed Timescale:** 30/12/2015

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the service prepared by the provider.

17. **Action Required:**
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

**Please state the actions you have taken or are planning to take:**
• The annual review of quality and safety of care will take place before 30/12/2015.
• The audit team have commenced unannounced audits nationally and will conduct twice yearly audits across the organisation.
• A copy of the report will be made available to service users and HIQA.
• An Annual Review and Annual Plan will be carried out on a yearly basis by the Management Team – this will be completed by 31/01/2016

Person/s Responsible
Service Manager – Assistant Manager – Service Quality Officer – National Health and Safety Officer – Head of Clinical Support

**Proposed Timescale:** 31/01/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were gaps in training provided to staff for example, movement and handling and medication management.
18. **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:**
- Updated moving and handling training for 6 staff and placement participants was provided on 28/10/2015
- Medication Management training for all relevant staff will be completed by 30/12/2015
- An organisational Review of Medication Management Policy will be completed by 30/12/2015

Person/s Responsible
Service Manager – Assistant Manager – CNM1

**Proposed Timescale:** 30/12/2015

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**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy was not implemented in practice.

19. **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:**
- Two service users with diabetes have had their care plans reviewed by the CNM1 and a new template to record dates and times of blood sugar checks has been introduced. 20/11/2016.
- Issues identified will guide practice and will be reviewed by the Management Team on a monthly basis.

Person/s Responsible
Service Manager – Assistant Manager- CNM1 – Senior Care Workers

**Proposed Timescale:** 30/12/2015

**Theme:** Use of Information
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in the records required to be maintained for residents, as outlined in Outcome 18.

20. 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:
• A review of all clinical records is currently being undertaken by the CNM1 and the Clinical Education Facilitator.
• Following this review all records will be updated and actions identified will be implemented by 30/12/2015
• The service roster now includes the shift pattern for all managers including PIC and PPIM and identifies the person in charge on any given day.

Person/s Responsible
Service Manager – Assistant Manager – CNM1 – Clinical Education Facilitator

Proposed Timescale: 30/12/2015