## Centre Information

<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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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003437</td>
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<td>Centre county:</td>
<td>Carlow</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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<tr>
<td>Provider Nominee:</td>
<td>Mark Blake-Knox</td>
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<tr>
<td>Lead inspector:</td>
<td>Caroline Connelly</td>
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<td>Support inspector(s):</td>
<td>Kieran Murphy</td>
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<tr>
<td>Type of inspection</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>21</td>
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<td>Number of vacancies on the date of inspection:</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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: To:
13 October 2015 11:00 13 October 2015 19:00
14 October 2015 08:30 14 October 2015 17:00

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

| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 02: Communication |
| Outcome 03: Family and personal relationships and links with the community |
| 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 10. General Welfare and Development |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 15: Absence of the person in charge |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

Summary of findings from this inspection
HIQA undertook a series of inspections of centres operated by Cheshire Foundation Ireland during 2015 and found a high level of non-compliances with the requirements of the regulations and the National Standards. In particular, inspectors found that the provider did not have adequate governance arrangements to ensure a safe and good quality of service for residents. The provider was required to attend a meeting with HIQA on 25 November and at that meeting, the provider told inspectors of a plan to reconfigure governance arrangements, improve support for local managers and address the areas of non compliance in each centre. Since that meeting, while there continues to be non compliances, HIQA has seen evidence that
the provider is implementing their actions to improve the services. Inspectors will continue to monitor these centres to ensure that the improvements are sustained.

This was a registration inspection of a Cheshire Ireland service in Tullow County Carlow which is one of a number of designated centers that come under the auspices of Cheshire Ireland. Cheshire Ireland provides a range of residential, and respite services throughout the country. Cheshire Ireland is governed by a board of directors. The responsibility for the operation of the organisation is delegated to a Chief Executive Officer (CEO) and a senior management team. The CEO is the nominated provider for the service. This centre provided care for residents with physical disabilities and neurological conditions.

The centre comprised of four separate areas. A main building provided accommodation in eight single rooms for service users. On site there was eight additional modern bungalows, located around a landscaped courtyard and linked to the main house by a covered passageway. There was a move in recent times to relocate residents from the congregated setting to individual houses in the community and away from the main site. There were plans to close the main building. A number of residents lived in a housing development, open since 2014, which consisted of six individual bungalow style accommodation close to the town. There was also an unoccupied, newly-renovated two-storey house, in another part of the town, that could accommodate four residents. During the inspection it was decided to register this house separately as a stand-alone centre and the provider had applied to the Authority to do so.

The registration inspection took place over three days and during this time the inspectors met residents, the provider, the person in charge, the assistant services manager, members of the management team, numerous staff members and relatives. Throughout the inspection inspectors observed practices and reviewed documentation which included residents’ records, policies and procedures in relation to the centre, medication management, accidents and incidents, complaints, health and safety documentation and staff files. The person in charge works full time and was seen to be very involved in the day-to-day running of the overall service. Staff and residents informed inspectors that the person in charge was accessible to residents, relatives and staff.

A number of questionnaires from residents and relatives were received and the inspectors spoke to the residents and a number of relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. However, there were some concerns expressed in relation to staffing levels and lack of staff facilities close to where residents were living. These issues were looked into during the inspection and are discussed under the relevant outcomes. The inspectors found that although the provider and the person in charge demonstrated adequate knowledge of the regulations and standards they had moved residents from the designated centre to a centre in the community prior to the completion of the consultation process with the Authority.

There was evidence of individual residents’ needs being met and the staff supported and encouraged residents to maintain their independence where possible.
Community and family involvement was evident and encouraged as observed by inspectors. The inspectors observed evidence of good practice during the inspection and were satisfied that residents received a good standard of healthcare with appropriate access to their own general practitioner (GP), psychiatry and allied health professional services as required. However, the inspectors found that there were a large number of major and moderate non compliances with the regulations and identified substantial improvements required in relation to fire safety, availability of staff at night, skill mix, staffing facilities, residents contracts of care, residents finances and protection, and health and safety. The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centers for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 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):
No actions were required from the previous inspection.

Findings:
Inspectors observed staff interaction with residents and noted staff promoted residents' dignity while also being respectful when providing assistance. There was some evidence that residents were consulted about how the centre was organised and residents meetings had taken place in the past. However, the person in charge said the residents did not want meetings and preferred discussions on a one-to-one basis. The assistant manager and the person in charge told the inspectors they met regularly with residents to discuss issues but these discussions were not always recorded so therefore there was not a contemporaneous record of discussions and actions taken in response to issues identified.

Inspectors were not satisfied that there was an effective complaints process in place to facilitate and support residents and/or their relatives to make a complaint. There was a local complaints policy and the centre did maintain a complaints log. However, the complaints log did not always record if the complainant was satisfied with the outcome of the complaint.

Inspectors were informed that two residents were wards of court (called a wardship). While there was documentation available in the centre in relation to the wardship for each of the two residents it wasn’t clear if it extended to the resident’s personal care or if it was confined to their financial affairs. There was evidence that any financial decisions made by and on behalf of these two people were being approved through the office of the wards of court.

The person in charge informed inspectors that she monitored safe-guarding practices by...
regularly speaking to residents and their representatives, and by reviewing the systems in place to ensure safe and respectful care was provided. Inspectors observed staff endeavouring to provide residents with as much choice and control as possible by facilitating residents’ individual preferences, for example in relation to their daily routine, meals, assisting residents in personalising their apartments and their choice of activities. Residents generally had their own self-contained apartments which promoted their privacy and dignity. The inspectors saw very personalised living arrangements in residents’ rooms with photographs, personal effects and furniture. There was adequate space for clothes and personal possessions in all bedrooms/apartments with adequate wardrobes and lockers.

**Judgment:**
Non Compliant - Moderate

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**Outcome 02: Communication**
*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspectors noted that residents had access to appropriate media, such as television, and radio. All residents had televisions in their rooms and many had their own computer/laptops and had access to the internet as required.

There was a communication policy available on the day of inspection and staff who spoke to the inspector demonstrated awareness of individual communication needs of residents in their care and could outline the systems that were in place to meet the diverse communication needs of residents. In addition, inspectors noted that individual communication requirements, including residents with complex communication needs, had been highlighted in personal plans and were also reflected in practice. For example, the inspectors noted that staff used communication approaches such as gestures, signals, facial expressions and vocalisations to communicate with some residents.

Inspectors noted from residents' personal plans that there had been input from multi-disciplinary professionals including speech and language therapists and occupational therapists to assist residents meet their range of communication needs. Staff to whom inspectors spoke outlined how residents were facilitated access, where required, to technology and communication aids.

**Judgment:**
Compliant
**Outcome 03: Family and personal relationships and links with the community**

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspectors noted there was an open visiting policy and relatives could visit without any restrictions. As residents all had their own apartments/houses private visiting was facilitated. The inspectors met a number of visitors in the centre during their inspection. There was evidence in residents’ personal plans showing visitors attending the centre at different times as well as regular planned visits and this was confirmed by relatives that spoke to the inspectors.

The inspectors saw and relatives confirmed that they were updated as required in relation to residents’ progress and many relatives attended residents’ review meetings. The inspectors saw in residents’ personal plans that these meetings were held on a regular basis. There was evidence that residents’ representatives could bring any issue directly to staff. Relatives spoken to and questionnaires confirmed to the inspectors that staff were very responsive to any such issues raised.

The inspectors saw that residents were supported to develop and maintain personal relationships and links with the wider community, and families are encouraged to be involved in the lives of residents. Some residents visited their family homes and relatives, and this was all documented as part of their personal plans. Overall, the inspectors saw evidence of good family involvement in care.

**Judgment:**
Compliant

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**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):**
No actions were required from the previous inspection.
**Findings:**
The person in charge informed inspectors that all prospective residents and their representatives were afforded an opportunity to visit the centre on numerous occasions and speak to staff prior to admission. The offer of any place is made in consultation with the HSE based on prioritisation.

The inspectors found that the criteria for admission was not clearly stipulated in the statement of purpose and in fact it stated the centre was not taking any new admissions. The person in charge confirmed this was only the case with regard to the main house which was closing. However, there would be admissions to other areas as vacancies occurred. There was no comprehensive admissions policy available. The person in charge informed the inspectors that consideration was always given to ensure that the needs and safety of the resident being admitted were considered along with the safety of other residents currently living in the centre. However, this required inclusion in the admissions policy. There was evidence that residents and relatives had visited the new house and liked their chosen rooms.

The inspector reviewed copies of the current written agreements in relation to the terms and conditions of residing in the centre. It was noted that the documents detailed the support, care and welfare of the resident, details of the services to be provided for that resident, and the fee to live in the centre. However, the service agreement was not comprehensive and did not meet the requirements of legislation as it did not stipulate the fees to be charged in relation to extra services provided by the service such as transport, meals, private hours and all other items the resident had to pay for in addition to the rent.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There was evidence that each resident was supported to develop an individual lifestyle
plan each year. The lifestyle plan supported the person to establish a circle of support made up of family members, friends, neighbours and any others who the resident was close to and from whom they wished to receive support. The individual lifestyle plan detailed what was important to the resident, and what they needed and wanted for a good life. The process was designed to allow input from the resident, support workers and family, to identify annual goals.

There was evidence of residents’ involvement in agreeing/setting residents’ goals which were marked as priorities. However, improvements were required to the process of setting these priorities. A number of the goals set were not clear and measurable and did not have goal focused plans with meaningful outcomes for the residents. It was not always clear who was responsible for supporting the resident to achieve these priorities. Also, the supports required for residents to achieve their priorities were not always specified.

Inspectors saw that specific support plans were in place for residents’ identified needs. This included plans for issues like intimate care, nutrition support and medication support. There was evidence of input from relevant healthcare professionals in the development of these support plans. There was evidence of interdisciplinary team involvement in residents’ care including, medical and General Practitioner (GP), speech and language, dentist and chiropody services. These will be discussed further in outcome 11 healthcare needs.

In relation to discharging a resident from the centre; in March 2015 the Authority received a notification from the centre regarding a resident who had been admitted to a hospital. The notification outlined that the service was reluctant to receive the resident back without appropriate supports being in place. While the resident had not been discharged at that time, on this inspection it was found that the service agreements in place with residents did not outline the terms and conditions whereby a resident may be discharged.

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):
No actions were required from the previous inspection.

#### Findings:
The centre was a seven day-residence open all year and currently provided
accommodation for 22 residents in four separate locations:

1. The campus
The original campus had seven spacious en-suite bedrooms, four of these bedrooms had a separate kitchenette area. This building also had a large communal dining room, a laundry, kitchen, physiotherapy area and office space. On the day of inspection two residents were living in the campus as part of a respite service. Of note is that it was proposed to move four residents from their current accommodation on the campus to another designated centre in a community setting.

2. The apartment
There was a self-contained apartment for one resident on campus (the apartment). The apartment had one bedroom, a sitting room, dining room, kitchen, bathroom and spare room.

3. The close
The close comprised six self-contained apartments in a social housing development near to the centre of town. Each apartment provided bungalow style accommodation consisting of an open plan living area and kitchen, two bedrooms and a bathroom with an enclosed back garden.

4. The villas
The villas were eight self-contained apartments built around a landscaped courtyard in the grounds of the original campus. Each apartment consisted of a kitchen/living room and a bedroom with en-suite bathroom.

All of these buildings were fully accessible. The apartments in the close and the villas had been modified so that the external doors could open by pushing a button. The fixtures and fittings, including sinks and cookers were designed to be accessible to all. Most residents were happy to show inspectors their apartment. All apartments were fully furnished and decorated in conjunction with the individual resident’s personal choice and taste.

It was proposed to change the villas into a community setting by removing any physical attachment to the campus, which was currently provided for by an enclosed corridor. It was also proposed to increase accessibility to each apartment in the villas by redesigning the entrance way so that each apartment could be reached via their own driveway.

There was plenty of gardens and outdoor space with suitable seating for residents to use and enjoy.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

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

Findings:
Inspectors identified a number of areas for improvement in relation to fire safety, risk assessment and the management of the organisation risk register.

There wasn’t a specific fire policy or overall guidance document in place for staff to respond to fire emergencies in any of the buildings that were part of the designated centre.

In relation to the campus building there were service records to show that the fire detection and alarm system, all fire extinguishers and the emergency lighting system had been serviced in September 2015. The single apartment and the apartments in the villas were all linked to the fire protection systems in the campus building. Inspectors saw a copy of a fire safety assessment report for fire safety upgrade works to the campus buildings from February 2014. It was unclear if the recommendations, and in particular the general recommendations, from this report had been completed. In addition, the centre had been the subject of an inspection in 2013 by the Fire Authority of Carlow County Council. Again, it was unclear if the actions from this report had been completed.

Inspectors found that fire precautions were inadequate in relation to each of the six apartments in the close. These included:
- no fire panel in place to indicate the location of a fire
- no record available to show if smoke alarms had been serviced
- no emergency lighting in place (which is lighting provided in the event of power failure to the regular lighting)
- no record available to show whether the fire extinguishers had been serviced.

Inspectors reviewed the incident reporting system from February 2015 to October 2015 and identified six incidents where a resident’s personal alarm had accidentally been dislodged or where the resident couldn’t reach their personal alarm. There were also two incidents where the fire alarm had been activated and one incident of the burglar alarm going off. Staff described the response to a fire emergency in the apartment in the close which involved the use of mobile phones to alert staff of a fire. On receipt of the call, night staff responded from a base approximately 500 metres away. Inspectors were not satisfied that this was an effective fire safety management system. Of note is that a similar fire emergency response system was proposed for the villas when the apartments there were to be part of a community setting.

Since the last inspection the risk management policy had been updated and included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. All of these issues were also identified as hazards and had been separately assessed and risk rated. However, the risk assessments had not always been completed fully. For example, the risk assessment for the use of chemical restraints had not been rated at all.
The centre had a risk register in place. An organisation risk register is designed to log all the hazards that the organisation was actively managing. However, improvement was required in the management of this risk register. In particular:
- It wasn’t clear how some risk issues relating to individual service users had been put on the risk register and other risk issues hadn’t.
- The methodology of assessing risk on the risk register, such as whether the risk was low, medium or high, was not the same method as in use for general risk assessment.
- It wasn’t always clear how the hazards on the risk register were being managed and who was responsible. For example, one hazard identified in June 2015 was that “the existing gate for the apartments in the close was too narrow”. It wasn’t clear how this hazard was being managed by the organisation.
- There were organisational hazards, for example the risk associated with the move of residents to community settings, that weren’t on the organisational risk register at all.
- It was also unclear if hazards on the risk register were being escalated to the management team of Cheshire Ireland.

The centre was visibly clean throughout and staff spoken with were knowledgeable about cleaning and control of infection.

**Judgment:**
Non Compliant - Major

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

**Findings:**

Since the last inspection there was now an up to date policy on, and procedures in place for, the prevention, detection and response to abuse.

Prior to the inspection the Authority had been notified of an allegation relating to resident protection which was being followed up appropriately. However, inspectors were not satisfied that all potential resident protection issues were being escalated and managed appropriately. Both the complaints log and the incident reporting system contained resident protection issues which had not been formally reviewed to safeguard both staff and residents.
There was an up-to-date policy on the use of restraint which was in line with evidence based practice. The policy outlined that consent to the use of restraint had to be obtained from the resident, and also that there had to be multidisciplinary assessment of the appropriateness of restraint. Restraint in this context included lap belts, bed rails and belts on wheelchairs. The care plans reviewed by inspectors reflected the key points of the policy in relation to multidisciplinary assessment and consent. Care plans outlined risk assessments for the use of a lap belt, use of a bed rail and use of a bed table when in bed. Each risk assessment outlined the consideration of alternatives to the use of restraint. Each restraint was subsequently risk rated and appropriate risk controls were seen. Inspectors also saw a register of all the types of restraint which were in use.

There was a policy on challenging behaviour which outlined that alternative options were considered before a restrictive practice was to be used. However, there was no evidence in residents’ personal plans that detailed behavioural support plans were in operation for residents who presented with behaviours that challenged and detailed de-escalation techniques were not outlined. There was evidence of review by the psychiatrist but there was little input from a psychologist and no behavioural plans prescribed. Training records and staff confirmed that staff had not received up-to-date training in the management of behaviours that challenged and due to the increasing number of incidents this training should be provided to staff as a matter of priority.

The inspectors reviewed the system in place to manage residents' finances and overall the inspectors were not satisfied that the system was sufficiently robust to ensure the safeguarding of residents. Not all residents had access to their own bank accounts and their monies were still being managed centrally in the finance department in the centre. The finance department pays bills for a number of residents and provides spending money via a shop account. The shop account has been in practice for numerous years and is indicative of institutionalised practices. The person in charge informed the inspectors that they are trying to move all residents from this system to a more independent system where they manage their own finances with assistance from the key workers and all residents will have their own bank account. Money competency assessments are being completed with residents and community connector staff are working with residents to encourage more independence. The inspectors saw evidence that residents were paying for extras such as transport, meals and private hours. These were not outlined in the residents' contracts of care as discussed previously and the inspectors were not satisfied that there were robust systems, policies and procedures in place to protect residents from misuse of the systems, particularly in the payment of regular staff for private hours and in payments for transport.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Notification of Incidents**

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.
### Theme: Safe Services

#### Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

#### Findings:
The inspectors found that there were a number of incidents that had not been notified to the Authority in accordance with legislation.
These included a resident admitted with pressure sores and resident going missing from the centre.

#### Judgment:
Non Compliant - Major

### Outcome 10. General Welfare and Development

*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

#### Theme:
Health and Development

#### Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

#### Findings:
The inspectors were satisfied that residents' opportunities for new experiences, social participation, education, training and employment were facilitated and supported. There was a policy on access to education, training and development. Inspectors noted that opportunities for further education were afforded to residents and the educational achievements of residents were valued. Many of the residents had their own laptops, computers and printers. One resident who enjoyed woodwork had a room set up in his apartment to work on his woodwork projects.

A community transition coordinator was working with the residents and had completed a distinctive identity portrait which was a narrative journey through a person’s life. This process also identified the person’s wishes regarding where they wanted to live. Further stages in the process involved meeting with other stakeholders like family members, HSE and community housing representatives. Comprehensive documentation regarding this transition was seen by inspectors to facilitate residents through the transition period and ensure they were prepared for community living.

#### 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):**

No actions were required from the previous inspection.

**Findings:**

Residents' healthcare needs were met through timely access to GP services. The inspectors saw that residents were assisted to access community-based medical services such as their own GP. They were supported to do so by staff who would accompany them to appointments and assisted in collecting the prescription as required. Out-of-hours services were provided by the local Caredoc service who attended the resident at home if necessary. One of the GP’s also visited the centre on a Wednesday each week to review any residents there as required.

Residents had access to allied health care services which reflected residents’ diverse needs. There was a physiotherapist employed one day per week and a physiotherapy assistant attended for two hours each day. Residents were seen to have appropriate access to other allied health care services such as occupational therapy, chiropody, optical and dental through the HSE and visits were organised as required by the staff. There was evidence in residents’ records of referrals to and assessments by allied health services and plans put in place to implement treatments required. The centre was nurse-led and the inspectors saw there were a number of validated tools in place for dependency, falls, nutrition and pressure sore formation. The inspectors found there were a number of residents with complex physical and nursing needs and were assessed as having maximum dependency needs. The inspectors acknowledged that measures and equipment were put in place such as a specialist mattresses, hoists and chairs. However the inspectors found, as outlined in outcome 17, that there was a requirement for extra nursing staff to prescribe and direct the care required for these residents, particularly in light of the nurse in charge being the only nurse in the service, at the time of the inspection, due to leave arrangements.

Residents’ records were viewed and the inspectors found that the records were contained in three different locations. The resident’s active file, which detailed personal care planning, was contained in the resident’s own apartment; the support file, which contained allied health professional details, was kept in the treatment room; contracts for the provision of care and historical medical records were maintained in the main centre office. The person in charge outlined that this tri-location of records would be reviewed to avoid a communication failure regarding a health issue. This is actioned under outcome 18 residents’ records.

In relation to nutrition the inspectors saw a weekly menu plan with a choice of different dishes for each day. Residents outlined that they could request a different option to the
menu if they so desired. The inspectors observed a pleasant dining experience at lunchtime. Any resident who required assistance with eating and drinking was supported in a discrete and sensitive manner. Inspectors saw evidence that each resident had a malnutrition universal screening tool (MUST) completed. There was evidence that residents were supported and enabled to eat and drink when necessary. For example, one resident with specific dietary requirements had a specific risk management plan for mealtimes. This plan identified swallowing difficulties and instructions were recorded from the speech and language therapist regarding food consistency. The kitchen communication book contained a record of this food consistency plan. Catering staff had recently completed a course on dysphagia (swallowing difficulties). All catering staff had up-to-date food safety and hygiene training. Residents expressed great satisfaction with the food available.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
The inspectors saw that the centre uses the Cheshire Ireland organisational policy on medication management but the policy was not centre specific and therefore did not outline local arrangements, this is actioned under outcome 18 in relation to records. Inspectors saw that the pharmacist transcribed the prescription on to the medication administration sheet. This transcription was then signed as accurate by the GP. Inspectors saw evidence that the pharmacist was involved in the review of residents’ medications on-site on a regular basis, and provided advice and support to staff. The input of the pharmacist had been sought in relation to medication management policies and procedures and there was evidence that the pharmacist was involved in the auditing of medication practices in the centre. Medication was dispensed in blister packs for each resident. The inspectors saw that references and resources were readily accessible for staff to confirm prescribed medication with identifiable drug information. This included a physical description of the medication and a colour photograph of the medication which is essential in the event of the need to withhold a medication, or in the case of a medication being dropped and requiring replacement. Unused medication was stored in a closed tamper proof box and then returned to the pharmacy. There was a standard operating procedure on the administration of medication from a blister pack system.

Each medication administration record had a picture of the resident. There was evidence that each resident was encouraged to take responsibility for their own medication in
accordance with their wishes and preferences. There was a policy on self administration of medication. Two residents had been risk assessed as being suitable to take their own medication. The staff monitored the daily self administration of medication by the resident. There was a current standard operating procedure on the reporting and recording of medication errors. On the previous inspection some staff spoken with felt that more comprehensive medication management training was required, on this inspection the inspectors saw that medication refresher training had been provided to all staff and there was evidence of the nursing staff completing assessments of the care staffs practices in relation to medication administration.

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. The quantity of controlled medications was checked by two staff at 08:00 hours and 20:00 hours. Staff displayed a good knowledge of controlled medications and the procedure outlined for administration.

Judgment:
Compliant

**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):**
No actions were required from the previous inspection.

**Findings:**
The statement of purpose was found to be comprehensive and contained all the relevant information to meet the requirements of Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However as the centre is going through a period of change and Mount Wosley lodge is registering as a separate centre, the statement of purpose will need to reflect these changes. Following the inspection the person in charge sent in an updated statement of purpose.

**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):**
No actions were required from the previous inspection.

**Findings:**
Cheshire Ireland provide a range of residential, and respite services throughout the country. Cheshire Ireland is governed by a board of directors. The responsibility for the operation of the organization is delegated to a Chief Executive Officer (CEO) and a senior management team. The CEO is the nominated provider for the service and the service manager for the centre is the person in charge.

There is an eastern regional manager who the person in charge reports to. The person in charge is supported in her role in the centre by the assistant manager and a CNM1 care team leader. There was also a quality services manager, a head of support services, head of maintenance, life style coordinator, an administrator, senior care workers and community transition coordinators as part of the management team.

The service manager is the person in charge for the service. The person in charge works full-time and has only managed the service for a number of months but was working in the service as a nurse prior to taking on the person in charge role. There was evidence that the person in charge had a commitment to her own continued professional development. The person in charge is a qualified general nurse and children's nurse. The inspectors formed the opinion that she had the required experience and clinical knowledge to ensure the effective care and welfare of residents in the centre.

Inspectors noted that residents and relatives were familiar with the person in charge and said they could speak to her if necessary. Residents and staff identified the person in charge as the one with overall authority and responsibility for the service. Staff who spoke to the inspectors were clear about whom to report to within the organisational line and of the management structures in the centre. The assistant service manager takes responsibility for the centre in the absence of the person in charge. Additionally the person in charge is available on call and staff told inspectors that they have called her in the past.

Inspectors noted that the person in charge and staff generally demonstrated a positive approach towards meeting regulatory requirements. The provider had employed the services of a consultant to undertake a full eighteen outcome announced review of the service focusing mainly on areas that required improvement. This comprehensive review had taken place in July 2015 and numerous actions and improvements required were identified. However, there was little evidence of action taken to address these issues and the inspectors found there were ongoing non compliances identified from the previous report. There was evidence of some quality audits being undertaken such as
audits of adverse incidents and medication audits, however inspectors found that these were not consistent and there was not an ongoing comprehensive review of the quality and safety of the service and of the care provided. There was no evidence of the provider or a nominee on behalf of the provider undertaking unannounced visits of the centre and there were no reports available. The inspectors were not satisfied that the system implemented to monitor the quality of care and experience of the residents was adequate to ensure the delivery of safe, effective services.

The inspectors found that although the provider and the person in charge demonstrated adequate knowledge of the regulations and standards, some residents had moved from the designated centre to a centre in the community prior to the completion of the consultation process with the Authority in relation to same.

Staff had told inspectors they had raised concerns regarding the safety of residents in one part of the centre and had raised concerns regarding staff not having facilities on site to be close to the residents in the event of an emergency. However there was no evidence of this documented in staff meetings.

**Judgment:**
Non Compliant - Major

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**Outcome 15: Absence of the person in charge**

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There had been a number of changes to the person in charge since the previous inspection. The previous person in charge vacated this post in May 2015. However, the authority was not notified of the absence of the person in charge for a period of 28 days or more as is required by legislation. A person in charge from another centre took charge for a short period prior to the current person in charge taking up the post in recent weeks. The provider also did not notify the chief inspector in writing of the procedures and arrangements that were put in place for the management of the designated centre during the absence of the person in charge.

The inspectors were satisfied with the current acting up arrangements put in place to cover for the absence of the current person in charge. The assistant service manager will act up as person in charge for the period of absence and she will be supported in her role by the clinical nurse manager and management team.

**Judgment:**
Non Compliant - Major
### Outcome 16: Use of Resources

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**
Use of Resources

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspectors formed the opinion that the centre was resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose. However, there were concerns around the provision of adequate staffing levels which is discussed under outcome 17.

The person in charge told the inspectors that the residents' care would not be compromised by budget constraints and if specialist equipment was required, funding would be provided.

The inspectors saw that there was sufficient assistive equipment to meet the needs of residents with servicing records for assistive equipment up-to-date. The inspectors noted that there was accessible transport services provided for residents which the service charges for.

**Judgment:**
Compliant

### 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:**
The centre directly employed 72 staff. There was also an extensive volunteering
programme in place which included community employment participants on a community employment scheme and job bridge programme.

A lifestyle facilitator coordinated all the personal assistants for residents, community employment workers and volunteers. A number of volunteers had been placed via the European Voluntary Service (EVS) programme. Each of these volunteers had to submit an expression of interest and an independent assessor inspected the service to see if it was suitable for placement. A Garda Síochána vetting was undertaken by the EVS programme. There was a handbook for all volunteers, a completed garda vetting form, a signed application form, three references and photographic identification.

Inspectors spoke to staff and observed them at work with the residents. Staff were knowledgeable about each resident’s needs and interacted with them in a respectful and dignified manner. Inspectors also spoke to some family members who were very complimentary about the staff that worked in the centre. Most staff had completed training which was required as mandatory by the regulations with the exception of training in behaviours that challenge, and this is actioned under outcome 8. Further education and training was also available to staff to ensure their knowledge base was current.

Inspectors reviewed a sample of staff files and although they contained evidence of Garda Síochána vetting, photographic identification and detailed work histories, the inspectors found that written references remained outstanding for two staff and there was no evidence of relevant qualifications in another file. Therefore they did not met the regulatory requirements.

The inspectors were not satisfied that planned night-time staffing levels, when residents move to the community based service, were adequate to meet the needs of the residents and the safety of staff travelling between services at night-time. Nursing staff were employed between 08:00 and 17:00 Monday and Friday. There was no nursing staff on duty at night, and nurses were not on duty at the weekend. However, there were arrangements in place for a nurse to attend for three hours at some stage during the weekend. There was an on call system at the weekend for nurses and management should staff have any queries. During the inspection and for a number of weeks, due to unplanned leave, the person in charge was the only nurse covering the service. This level of nursing cover is not satisfactory as the person in charge’s nursing duties were never replaced when she undertook the acting person in charge role. Due to the complex and maximum dependencies of many of the residents these nursing arrangements require immediate review and this was outlined at the feedback meeting. The centre also provided support to two former residents who lived independently in the community. In the event of an emergency situation for one of these residents between 22:00 hrs and 08:15 hours, the arrangements were that one of the two staff members on duty would respond, thereby leaving only one staff member behind in the centre. Inspectors formed the opinion that staff levels at night in relation to responding to external emergencies and nursing cover should be formally reviewed.

The care team leader who was a registered nurse had responsibility for ensuring that each resident had care which was appropriate and evidence based. This responsibility extended to clinical supervision of all non-nursing staff. Inspectors formed the opinion
that while the quality of care was good this level of supervision of care was not adequate.
There was evidence of staff meetings held, but there were no minutes and records of recent issues discussed.

**Judgment:**
Non Compliant - Major

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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):**
No actions were required from the previous inspection.

**Findings:**
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 were generally maintained. The centre was adequately insured against accidents or injury to residents, staff and visitors. Staff to whom inspectors spoke demonstrated an understanding of specific polices such as medication policy and managing allegations of adult abuse in practice. However, the inspectors reviewed the centre's policies and procedures and found that the centre did not have 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. In that the admissions policy and policies in relation to records management were not available. The medication policy as discussed under outcome 12 was not centre specific.

In relation to residents' records as discussed in outcome 11 the inspectors saw that there were numerous files maintained for each resident and that the records were contained in three different locations. The resident’s active file, which detailed personal care planning, was contained in the resident’s own apartment; the support file, which contained allied health professional details, was kept in the treatment room; contracts for the provision of care and historical medical records were maintained in the main centre office. Therefore, there was at times duplication of information which could lead to the most current information not being available to guide care and treatment.
The inspectors reviewed the directory of residents and noted that the directory was completed for each resident and contained the required information.

**Judgment:**
Non Compliant - Moderate

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**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:**

Caroline Connelly  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Provider’s response to inspection report

Centre name: A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID: OSV-0003437
Date of Inspection: 13 October 2015
Date of response: 01 December 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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no clear documentation relating to the wardship arrangement for two residents.

1. Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

**Please state the actions you have taken or are planning to take:**
- Correspondence will take place with Ward of Court to ascertain status of wardship and documentation to outline this status will be requested for Service Users file.
- A letter to be drafted by the Service manager on week beginning 7th December to request this information.

**Proposed Timescale:** 31/03/2016  
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The assistant manager and the person in charge told the inspectors they met regularly with residents to discuss issues but these discussions were not always recorded. Therefore, there was no contemporaneous record of discussions and actions taken in response to issues identified.

2. **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.

**Please state the actions you have taken or are planning to take:**  
A meeting record form has been implemented by the Person in Charge and Assistant manager which is now used to document meetings held with service users, actions taken and responses to issues identified. This is kept on file in the main office.

**Proposed Timescale:** 31/10/2015  
**Theme:** Individualised Supports and Care

The complaints log did not always record if the complainant was satisfied with the outcome of the complaint.

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:**  
a) The complaints form is currently under review and new version will include section to
document whether the complainant was satisfied or not.
b) The service has an electronic complaints database that is completed when complaints are made. This includes a section to document whether the complainant is satisfied with outcome or not.
c) Currently the Service has implemented an associated document with complaints form which allows the nominated person to document whether complainant is satisfied or not.

**Proposed Timescale:** 28/02/2016

**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:
There was no comprehensive admissions policy available and the policy did not take account of the need to protect residents from abuse by their peers.

4. **Action Required:**
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
A revised Admission Policy has been introduced by Person in Charge with assistance from Service Quality Team for Cheshire Ireland in November 2015 which includes taking into account the need to protect residents from abuse by their peers.

Proposed Timescale:  Policy in place November 2015 - completed

**Proposed Timescale:** 30/11/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The service agreement was not comprehensive and did not meet the requirements of legislation as it did not stipulate the fees to be charged in relation to extra services provided by the service such as transport, meals, private hours and all other items the resident had to pay for in addition to the rent.

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

a) Currently the Service Agreement is under review by Person in Charge with support from the Service Quality Team to ensure the agreement complies with regulatory requirements.

b) The person in charge will implement an addendum to the current Service Agreement which will outline fees to be charged in relation to extra services provided by the Service to the Service User such as transport, meals, private hours etc.

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

### 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:

Those responsible for supporting residents in pursuing goals were not always clearly identified nor were the supports outlined.

6. **Action Required:**

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

a) A full review of all Service User’s lifestyle plans will take place by Nursing and Care Staff Team to include each Service User’s key care support worker.

b) New amended lifestyle plans will be implemented with clear goals identified and a plan formulated to outline how these individual goals will be achieved.

c) An audit will take place each quarter in 2016 to ensure Service User’s goals being pursued have been successful and meaningful.

Proposed Timescale: Lifestyle Plans will be reviewed in January 2016 and implemented by 1st March 2016. An audit of filled will take place in June and October 2016 by Clinical Nurse Manager and Senior care Workers.

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The service agreements in place with residents did not outline the terms and conditions whereby a resident may be discharged.

7. **Action Required:**
Under Regulation 25 (4) (e) you are required to: Ensure the discharge of residents from the designated centre is in accordance with the terms and conditions of their agreements for the provision of services.

**Please state the actions you have taken or are planning to take:**
Person in Charge and Service Quality team to review Service Agreement to ensure the discharge of service users from the designated centre is in accordance with the terms and conditions of their agreements for the provision of services.

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

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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:
The risk assessments had not always been completed fully. For example the risk assessment for the use of chemical restraints had not been rated at all.

8. **Action Required:**
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**
a) A gap analysis is currently being undertaken by the Health and Safety Officer on The Risk Management and Safety Management system within Cheshire Ireland. On review of this, the risk management system will be revised and implemented.

b) Safety Representative training program is being drafted and the safety representative training will take place at St. Patricks Cheshire. This will give the safety representative the tools required to assist him to carry out this function while ensuring the risk culture is communicated and corrective actions are put in place to remove the risks.

c) Health and Safety Officer will conduct training for staff around how to conduct risk assessment. On-going to drive the safety culture and the importance of risk elimination.

d) Health and safety meetings to be held monthly until April 2016 continiuing the importance of risk communication .Reduce risk and eliminate risk when possible.

e) The Health and Safety Officer, Service Manager, Staff, and the safety representative to conduct the following risk assessments which in turn will aid the service in managing risk throughout the service.
f) Types of Risk Assessments:
1. Site specific risk assessments
   Generic risk assessments

g) Risk management training to be undertaken with key staff in the service.

h) Health and safety training to be given to staff in the service to assist with on-going improvements in safety culture and communication throughout the service.

i) A Self-Assessment Health & Safety Audit tool has been drafted by the new Health and Safety Officer (HSO). The Service Manager will complete this audit bi-monthly and send to the HSO for review. This audit tool will assist the service to ensure health and safety auditing is on-going. Both the Health and Safety Officer and the Service Manager will review the risks together in the service. The following areas will be audited: safety, fire safety, security, food safety and compliance documentation.

j) Unannounced and announced risk management audits will be undertaken on an on-going basis by the Health and Safety Officer. Findings and results of these internal audits will allow Cheshire Ireland to determine if the new safety practices, life safety systems and emergency plans are operating and facilitating the service correctly.

k) Health and safety meetings to be held monthly until April 2016. Findings on adverse events and other health and safety issues/corrective etc. to be discussed with staff and residents

Proposed Timescale: 30/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The organisation risk register required review.

9. 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:
a) A gap analysis is currently being undertaken by the Health and Safety Officer on The Risk Management and Safety Management system within Cheshire Ireland. On review of this, the risk management system will be revised and implemented.

b) Safety Representative training program is being drafted and the safety representative training will take place at St. Patricks Cheshire. This will give the safety representative the tools required to assist him to carry out this function while ensuring the risk culture is communicated and corrective actions are put in place to remove the risks.
c) Health and Safety Officer will conduct training for staff around how to conduct risk assessment. On-going to drive the safety culture and the importance of risk elimination.

d) Health and safety meetings to be held monthly until April 2016 continuing the importance of risk communication. Reduce risk and eliminate risk when possible.

e) The Health and Safety Officer, Service Manager, Staff, and the safety representative to conduct the following risk assessments which in turn will aid the service in managing risk throughout the service.

f) Types of Risk Assessments:
   2 Site specific risk assessments
   Generic risk assessments

g) Risk management training to be undertaken with key staff in the service.

h) Health and safety training to be given to staff in the service to assist with on-going improvements in safety culture and communication throughout the service.

i) A Self-Assessment Health & Safety Audit tool has been drafted by the new Health and Safety Officer (HSO). The Service Manager will complete this audit bi-monthly and send to the HSO for review. This audit tool will assist the service to ensure health and safety auditing is on-going. Both the Health and Safety Officer and the Service Manager will review the risks together in the service. The following areas will be audited: safety, fire safety, security, food safety and compliance documentation.

j) Unannounced and announced risk management audits will be undertaken on an on-going basis by the Health and Safety Officer. Findings and results of these internal audits will allow Cheshire Ireland to determine if the new safety practices, life safety systems and emergency plans are operating and facilitating the service correctly.

k) Health and safety meetings to be held monthly until April 2016. Findings on adverse events and other health and safety issues/corrective etc. to be discussed with staff and residents

**Proposed Timescale:** 30/04/2016

**Theme:** Effective Services

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

There was no specific fire policy or overall guidance document in place for staff to respond to fire emergencies in any of the buildings that were part of the designated centre.

**10. Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**
Fire policy is currently under review to be site specific to Leonardsville and Abbey Close to include a guidance document /evacuation plan for each building in the designated centre.

**Proposed Timescale:** 31/01/2016  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The response to a fire emergency involved the use of mobile phones to alert staff of a fire in the apartment in the close. On receipt of the call, night staff respond from a base approximately 500 metres away. Inspectors were not satisfied that this was an effective fire safety management system. Of note is that a similar fire emergency response system was proposed for the villas when the apartments there were to be part of a community setting.

**11. Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**
a) Fire safety management system will be reviewed for both Leonardsville and Abbey Close.  
b) A staff facility adjacent to service users houses has been included in plans for Leonardsville which will ensure a prompt response time from staff in the event of a fire.  
c) Abbey Close (with review of staffing levels) will have presence of staff 24 hours a day 7 days a week to ensure there is a safe and adequate response in the event of a fire.

**Proposed Timescale:** 31/01/2016  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no records available to show whether the fire extinguishers had been serviced.

**12. Action Required:**
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.
Please state the actions you have taken or are planning to take:
The week following inspection fire extinguishers were serviced at Abbey Close and this was documented. There is a plan going forward that servicing will be performed according to regulations in the future.

Proposed Timescale: Completed - October 2015

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no emergency lighting in place (which is lighting provided in the event of power failure to the regular lighting).

13. **Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
Quotations currently being sought as per Cheshire Ireland’s Policy to install emergency lighting in Abbey Close.

Proposed Timescale: Quotes x 3 will be obtained by 16th December Proposed date of instillation by 15th January 2016

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no records available to show if smoke alarms had been serviced.

14. **Action Required:**
Under Regulation 28 (3) (b) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
Following the HIQA inspection smoke alarms were serviced and a plan in place to continue to check and service the smoke alarms in the future.

| Proposed Timescale: | 31/10/2015 |
Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was limited multidisciplinary input and prescribed behavioural plans input to ensure that staff have up-to-date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

15. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
Training being implemented as above to ensure that staff going forward will have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Proposed Timescale: 28/02/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received up to date training in the management of behaviour that is challenging including de-escalation and intervention techniques.

16. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
a) Person in charge has in conjunction with the assistance of National training and development manager for Cheshire Ireland have sourced training with an accredited training company. Joe Wolfe and Associates will facilitate training with staff on positive behavioural support.
b) A qualified psychologist (Ms Margaret Costello) based in Carlow has been sourced to facilitate training in challenging behaviour with specific care staff looking after one service user who has been identified by service as challenging. She will provide training for staff on how to deal with this and also assist in implementing behavioural support plan around this gentleman.
c) New Policy on Positive Behavioural Support has been introduced by Cheshire Ireland and has been introduced into the service for staff.
<table>
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<tr>
<th>Proposed Timescale:</th>
<th>Policy Introduced on 23rd November and all Staff to be trained by 28th February 2016</th>
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**Proposed Timescale: 28/02/2016**
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The systems in place to manage residents’ finances were not sufficiently robust. The inspectors saw evidence that residents were paying for extras such as transport, meals and private hours. These were not outlined in residents’ contracts of care and the inspectors were not satisfied that there were robust systems, policies and procedures in place to protect residents from misuse of the systems particularly in the payment of regular staff for private hours and payments for transport.

**17. Action Required:**
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

**Please state the actions you have taken or are planning to take:**
a) Service Agreements for Service Users to be amended to include an outline of extra payments around transport, meals and private hours.
b) Working Group with Service Quality Team lead has been formed to review Service Users contracts of care around private hours and transport.
c) The function of this group is to recommend policy and procedures around the use of private hours and transport to ensure a more robust system governing this in the Services and to ensure policy and protocols that are implemented protect residents.
d) Person in Charge is a member of this working group and will be involved in implementing these changes in the service.

<table>
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<tr>
<th>Proposed Timescale:</th>
<th>31/03/2016</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Safe Services</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors were not satisfied that all potential resident protection issues were being escalated and managed appropriately.

**18. 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:
   a) Person in Charge will ensure that all resident protection issues will be escalated and managed appropriately
   b) Policies and Procedures are in place to ensure appropriate action is taken where a service user is harmed or suffers abuse.
   c) A NF06 form will be submitted in the event of an allegation
   d) All staff are trained in Adult Protection and protocol in reporting abuse.

Proposed Timescale: 31/01/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The Authority was not notified in relation to a resident being admitted with a pressure sore stage 2 or above, as is required by regulation.

19. Action Required:
Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

Please state the actions you have taken or are planning to take:
Notification sent 27/11/15 to HIQA and an update on status of service user to date.
In future all notifications will be sent to HIQA within 3 working days of the incident.

Proposed Timescale: 27th November 2015 – Completed

Proposed Timescale: 27/11/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One of the residents went absent from the centre and this had not been notified to the Authority.

20. Action Required:
Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.
Please state the actions you have taken or are planning to take:
Notification sent 27/11/15 to HIQA and an update on status of service user to date. In future all notifications will be sent to HIQA within 3 working days of the incident.

Proposed Timescale: 27th November 2015 – Completed

Proposed Timescale: 27/11/2015

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 there was no evidence of an unannounced visit to the designated centre at least once every six months, or more frequently as determined by the chief inspector. There was no written report on the safety and quality of care and support provided in the centre and no plan in place to address any concerns regarding the standard of care and support.

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

Please state the actions you have taken or are planning to take:
One unannounced visit / audit was carried out in July 2015

A review of the current quality audit system within Cheshire Ireland is underway. A working group has been appointed which will ensure that a robust structure of audit will be in place within the organisation. An audit tool has been developed and unannounced audits have commenced throughout the organisation. A schedule of audits for 2016 is currently being developed, which will include dates for 2 unannounced audits of this designated centre in 2016

Proposed Timescale: One unannounced visit / audit will be carried out prior to 30th June 2016. A second unannounced visit / audit will be carried out prior to 31st December 2016
Responsible Individual(s): National Cheshire Ireland audit team(s)
Proposed Timescale: 31/12/2016  
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors were not satisfied that the system implemented to monitor the quality of care and experience of the residents was adequate to ensure the delivery of safe, effective services.

22. 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 service user questionnaire/survey is currently being drafted by Service Quality Team which will be circulated in the New Year and feedback from the survey will be reviewed to ensure the service we provide is safe, appropriate to residents needs.

Proposed Timescale: 31/01/2016  
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff had told inspectors they had raised concerns re the safety of residents in one part of the centre and had raised concerns re staff not having facilities on site to be close to the residents in the event of an emergency, however there was no evidence of this documented in staff meetings.

23. Action Required:  
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:
a)Person in Charge will ensure that she will facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.  
b)This will be done by fostering a work environment which encourages staff to discuss concerns  
c)Care Staff meetings will be held regularly and minutes of meetings will be documented and agreed.  
d)Minutes of meetings will be circulated to staff.  
e)Staff concerns around facilities would have been documented during consultation process in August and September with unions.
Proposed Timescale: 26th November 2015 – Completed
Meetings will be held with Care Staff team monthly.

Proposed Timescale: 26/11/2015

**Outcome 15: Absence of the person in charge**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The Authority had not been notified of the absence of the person in charge as required by the regulations.

**24. Action Required:**
Under Regulation 32 (1) you are required to: Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

**Please state the actions you have taken or are planning to take:**
The Provider Nominee notified the Authority of the previous Person in Charge’s absence by email on 10th June 2015.
An NF30 pack was submitted to the Authority in relation to the current Person in Charge commencing her post.
The Statement of Purpose has been amended to reflect the changes in the management structure within the service.

Proposed Timescale: Completed
Responsible Individual(s): Provider Nominee & Person in Charge

**Proposed Timescale: 01/12/2015**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider did not notify the chief inspector in writing of the procedures and arrangements that were in place for the management of the designated centre during the absence of the person in charge.

**25. Action Required:**
Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.
Please state the actions you have taken or are planning to take:
Charge’s absence by email on 10th June 2015.
An NF30 pack was submitted to the Authority in relation to the current Person in Charge PIC commencing her post.
The Statement of Purpose has been amended to reflect the changes in the management structure within the service

Proposed Timescale: Completed
Responsible Individual(s): Provider Nominee & Person in Charge

Proposed Timescale: 01/12/2015

Outcome 17: Workforce
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All information and documents as specified in Schedule 2 were not obtained for all staff.

26. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
a) All staff files are currently being reviewed to ensure all documents required are obtained for all staff.
b) Files that were reviewed during inspection now contain all documents required under regulations
c) It is proposed to perform bi-annual audit of files using regulations to ensure staff files in the Service contain all documents required.

Proposed Timescale: 31st March 2016 all files will have been reviewed.
File Audit to take place 10th May 2016 and 10th November 2016.

Proposed Timescale: 30/11/2016
Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors found that the proposed staffing levels for night time required review prior to a move away from the main centre.
27. **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) A full review of staffing levels prior to the move from main building will be undertaken.
b) In consultation with transition team and HR it has been agreed subject to budget approval that an extra roving Care Staff member will be added to our current establishment on night duty.

**Proposed Timescale:** 31/01/2016  
**Theme:** Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The inspectors were not satisfied that there were sufficient nursing staff to meet the ongoing nursing needs of the residents and to provide supervision to the care staff.

28. **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:**
Currently the service has 1 WTE CNM 1.

Consultation is taking place with senior management around new community structure and requirement for nursing supervision as the service evolves. When nursing hours are agreed recruitment and selection will commence. Recruitment has commenced to cover maternity leave for current CNM1 from January 2016.

Proposed Timescale: 30th November 2015 nurse post will be advertised for maternity leave Agreement by 31st January 2016 for nursing hours requirements in new community structure.

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

**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 centre did not have 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. In that the admissions policy and policies in relation to records management were not available and the medication policy was not centre specific.

29. **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:**
- a) Admission Policy (revised) has been implemented and on Cheshire Ireland website.
- b) A draft Records Management Policy has been developed and awaiting sign off by Senior Management.
- c) The Medication Policy is currently under review and once implemented will be amended to be centre specific.

Proposed Timescale: Admission Policy _ October 2015 – Completed
Records management policy to be completed by 1st February 2016
Medication Policy to be made site specific by February 25th 2016.

**Proposed Timescale:** 25/02/2016

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents’ records and information in relation to residents were kept in various locations. There was at times duplication of information which could lead to the most current information not being available to guide care and treatment.

30. **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) A full review of files will be undertaken by CNM1 and Service Manager.
- b) Consultation will take place with Clinical Lead of Cheshire Ireland.
- c) A new filing system will be implemented to ensure service users information being reviewed and used on a daily basis is the most current and up to date information to guide care and treatment.

**Proposed Timescale:** 30/04/2016