<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003439</td>
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<td>Centre county:</td>
<td>Cork</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>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Louisa Power</td>
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<tr>
<td>Support inspector(s):</td>
<td>Kieran Murphy</td>
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<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>19</td>
</tr>
<tr>
<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 monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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</thead>
<tbody>
<tr>
<td>07 January 2016 07:30</td>
<td>07 January 2016 15:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<tr>
<td>Outcome 17: Workforce</td>
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</tbody>
</table>

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.

The inspection was an unannounced inspection to follow up on the actions of the previous inspection and was the third inspection of the centre. The purpose of this inspection was to follow up on the actions from previous inspections in 2015.

An announced inspection over two days to inform a registration decision had been completed on 01 and 02 July 2015. During the inspection, significant deviation from the Regulations was found with 13 of the 18 outcomes examined being judged as
A regulatory meeting was held with the provider nominee in the Authority's Head Offices on 05 October 2015 to discuss the significant findings and a warning letter was issued to the provider at this meeting.

An unannounced inspection was undertaken on 04 December 2015 to follow up on the actions from the first inspection. Inspectors saw that a good level of improvement had been made. Of the 15 outcomes examined during the inspection, one outcome was judged to be major non-compliant, three outcomes were judged to be moderate non-compliant and 11 outcomes were judged to be compliant or substantially compliant. The outstanding issues of concern following the inspection included medicines management and monitoring of residents.

As part of the inspection, inspectors met with residents, the person in charge, clinical nurse managers and other staff members. Inspectors reviewed the policies and procedures in the centre and reviewed documentation in relation to aspects of care such as medication management, complaints, safeguarding and safety, personal plans, staff files, fire safety management records and the training matrix. Inspectors found that the improvements seen during the inspection of 04 December 2015 had not been sustained. Inspectors found that there was limited progress made against the provider's action plan from the previous inspection in some areas. A major non-compliance was identified in Outcome 07: Health and Safety that resulted in an immediate action being issued on the day of inspection in relation to inadequate fire safety arrangements. An adequate response within the required time lines to this immediate action plan was provided. Inspectors found that Outcome 12: Medication management remained at the level of major non-compliance due to ongoing inappropriate medicines management practices and a lack of a rigorous response to medication related incidents. There were inadequate arrangements in place to develop, implement and review personal plans in relation to healthcare. Based on the findings of this inspection, it was concluded that there are not effective management systems in place to sustain improvement and to ensure the delivery of a safe and consistent service.

The centre was comprised of a large period style house which could accommodate eight residents, nine self-contained apartments and one house ('Sycamore House') where four residents, who had transitioned from the main house, now resided. A good rapport between residents and staff was evident throughout the inspection and staff supported residents in a respectful and dignified manner. Residents with whom inspectors met spoke positively in relation to the care and support provided to them. Residents reported that they participated in activities that they enjoyed and were meaningful for them.

These non-compliances are discussed in the body of the report and the action plan at the end of the report.
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:
Only the aspect in relation to the recent installation of a close circuit television system with voice sensor to monitor a vulnerable resident who was not physically able to use the call bell system and the related impact on the resident’s right to privacy was examined as part of this inspection. There was a clear documented rationale for the use of the system and a protocol was in place. Staff with whom inspectors spoke were aware of the system and the associated protocol. Informed verbal consent had been obtained from the resident in relation to the use of the system. The system was a live stream and therefore did not record data. Some consideration had been given to the resident’s privacy and dignity in the protocol. However, there was not a documented log of when the system was switched on and off to ensure the privacy of the resident was respected especially when personal care was carried out or when visitors were present.

Judgment:
Substantially Compliant

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

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

Findings:
At the previous inspection in December 2015, it had been identified that the fees for services were not set out for residents and contracts lacked sufficient detail as to the supports provided to residents. In addition, there had been a lack of clarity around the type of contract available to each resident. The proposed time scale outlined in the provider’s action plan had not yet passed and inspectors noted that adequate progress had been made.

On this inspection, there was a clear system in place in relation to the type of contact for each resident. The person in charge made copies of the updated contracts that were in draft available to inspectors. Inspectors noted that, whilst the fees to be charged were included, additional details were required in relation to the support, care and welfare provided to residents within the centre.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
During the previous inspection in December 2015, it was identified that the external walls of the main ‘period style’ house required repainting and the basement kitchenette required upgrading. The proposed time scale outlined in the provider’s action plan had not yet passed and inspectors noted that adequate progress had been made. The person in charge provided evidence to inspectors that quotations had been sought in relation to the work required.

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

**Findings:**  
At the previous inspection in December 2015, it was identified that documentation in relation to nightly checks and fire safety were incomplete and preventative actions were not outlined or were not robust for medicines related incidents. The proposed time scale outlined in the provider's action plan had not yet passed for some of the actions and inspectors noted that inadequate progress had been made.

Inspectors found that the provider was failing to ensure that staff were aware of the procedure to be followed in the case of fire by not having fire drills at recommended intervals. The provider was asked for an immediate action plan response to undertake fire drills as a matter of urgency to ensure the safety of residents. An adequate response was provided to the Authority within the required time lines to this immediate action plan.

On the previous inspection in December 2015, it was found that fire safety remedial works had commenced in the main 'period style' house. These works included upgrading of some fire doors, introduction of fire seals into existing doors and the introduction of fire rated 'downlights' throughout. On this inspection, while most of the works had been completed, there were still a number of issues outstanding. The service had engaged fire safety engineers who had recommended that, while the fire safety remedial works were ongoing, fire drills were to be undertaken monthly and all staff were to be trained in fire safety protocols. The person in charge acknowledged that monthly fire drills had not been undertaken as per the recommendations of the fire safety engineers. In addition, the night staff who spoke with an inspector stated that they had not taken part in any fire drills. Inspectors also saw an incident report for a false fire alarm activation on 03 January 2016. On that occasion, staff had contacted the out of hours emergency on call as they were not clear as to the location code displayed on the fire alarm panel as 'link corridor'. Following the incident, the fire alarm panel was examined by a suitably qualified person. On the day of inspection, a plan indicating the areas covered by the fire panel was readily available near the fire panel.

During this inspection, the main fire safety installations of fire alarm panel, emergency lighting and fire extinguishers were all within their statutory inspection schedules with all relevant certificates available on site.

An inspector reviewed a sample of night time checklists of door closures, designated fire doors to be closed and window closures. As on the previous inspection, it was noted...
that there were gaps in these night time checklists on four nights out of 33 nights since the last inspection.

Staff with whom inspectors spoke confirmed that three residents were not physically able to use the call bell system to summon assistance. As a control measure, night staff were to check these residents on a half hourly basis and the checks were to be documented. Inspectors viewed a sample of the documented records; the documentation was incomplete. For example, on two nights within the same week, two gaps of up to 120 minutes without a documented check were noted for one resident.

There was an incident reporting system in place and inspectors saw records for 46 incidents from September 2015 to January 2016 which included 18 resident trips/falls and seven fire related incidents. A separate system was in place to identify, record, investigate and learn from medication related incidents. An inspector reviewed the medication related incident forms from the previous inspection on 04 December 2015. A total of 12 medication related incidents had been reported; 11 of which were actual incidents and one was a near miss. Learning from the incidents was not documented in the majority of forms reviewed. The incident forms indicated that similar incidents were repeated. For example, there were five separate incidents of a medicine being omitted and these medicines included antibiotics and medicines to prevent seizures where missed doses could have significant consequences on the health and safety of residents. The repetitive nature of this risk had not been adequately assessed and timely steps had not been taken to minimise the potential harm.

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

**Findings:**
At the previous inspection in December 2015, it was identified that a small number of staff required training in the management of behaviour that is challenging including de-escalation and intervention techniques. The proposed time scale outlined in the
provider's action plan had not yet passed for some of the actions and inspectors noted that adequate progress had been made. The training matrix indicated and the person in charge confirmed that training had been provided since the last inspection but one staff member had yet to receive training. The staff member had been booked onto a training session in January 2016.

Judgment:
Substantially 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:
At the previous inspection in December 2015, it was identified that residents who were prescribed pain relief did not have relevant and supporting documentation available in their personal plans. The proposed time scale in the provider's action plan had not passed but inspectors saw that no progress had been made in relation to this finding.

A sample of residents' personal plans were reviewed by inspectors and considerable deficiencies were noted in relation to the development, implementation and review of personal plans in line with current assessed healthcare needs. The part of the personal plan that related to health did not always reflect the assessed needs of residents. Therefore there was a significant risk that some or all of residents' healthcare needs would not be met.

Residents who were prescribed pain relief did not have care plans in place in relation to the management of pain. In addition, there were two evidence based pain assessment tools in each resident's personal plan but there was no guidance for staff in relation to the most appropriate tool to use for each resident in line with their assessed needs. One tool used a visual scale (0-10) for residents to self-report pain. The other tool was an observational tool to be used by staff where a score was given to each indicator of pain observed and the maximum score for this tool was six. There was no guidance to staff in relation to management of pain based on the varying results from the two tools. There was no indication of either tool being used prior to and following the administration of pain relief to ensure that the appropriate treatment had been provided or the effectiveness of the treatment administered. Where two or more forms of pain relief were prescribed on an 'as required' basis, there was no guidance for staff in relation to the appropriate administration of the medicines. Inspectors noted that the pain relief prescription for a resident had recently been increased but no care plan was in place to guide staff in relation to this change and evidence based tools were not being
used to monitor the effectiveness of the change of treatment.

At the time of the inspection, there were two sets of resident healthcare records. The 'active file' contained the person centred plan and some medical information. The 'active file' was used on a day-to-day basis. The 'support file' was a separate file mainly for medical records. Inconsistencies were noted in the information available in the active file and the support file. For example, where a resident had a protocol in place for the administration of emergency medication, the dose to be administered was not clear. In the resident's 'active file', the protocol dated 30 June 2015 indicated that 10mg was to be administered. In the 'support' file, the protocol dated 01 July 2015 indicated that 5mg was to be administered. The prescription for this medicine, last reviewed in December 2015 by the prescriber, stated that 10mg was to be administered.

The personal plans were not being updated to ensure appropriate healthcare for each resident. There was evidence that, when a resident returned from hospital, all relevant information regarding the treatment received while in hospital was obtained by the centre. Both medical and nursing treatment letters from the hospital were readily available in the 'support file'. However, there was no documentary evidence available to inspectors to show that the instructions on the treatment letters had been followed. In particular, a plan of care and support for the identified healthcare needs had not been developed to reflect these instructions. Inspectors noted that plans of care were not implemented such as the completion of food and fluid charts where a resident was not eating and drinking well following return from hospital.

Inspectors saw that the communication diary contained a number of original hospital consultant out-patient appointment records stapled into the diary. This filing method could not guarantee the confidentiality of residents’ personal information.

In relation to wound care, care plans were developed where appropriate. The dimensions and condition of the wounds were documented on an ongoing basis. Nursing staff with whom inspectors spoke were familiar with the wounds to be treated, the management plan and their current status. However, this comprehensive information was not included in the residents' personal plan and plans were not updated following hospital appointments to ensure that the treatment advised at the appointments was implemented by all staff on a consistent basis.

The resident’s active file also contained an appointment log for relevant consultant out-patient visits or planned x-rays. In one example, a resident attended the acute hospital for a minor procedure. Following the procedure, specific advice had been given by the hospital team in relation to the trial of new devices to support the resident. Nursing staff were aware of the advice given but a care plan had not been developed to guide care staff who work at night, without on-site nursing cover, in relation to this. Night care staff with whom an inspector spoke were unclear as to the procedure completed in the acute hospital and the discharge advice given. In another example a resident had a planned x-ray for November 2015. It wasn’t clear in the documentation available to inspectors whether this x-ray had been completed.

**Judgment:**
Non Compliant - Major
Outcome 12. Medication Management

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

Theme:
Health and Development

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

Findings:
At the previous inspection in December 2015, it was noted that there were unsuitable and inadequate practices in relation to the administration, documentation and reviewing of medicines management practices. An action plan was submitted by the provider following the inspection and the proposed time scales had not yet passed. Inspectors found that the medicines management outcome was found to remain at the level of major non-compliance due to ongoing inappropriate medicines management practices and a lack of a rigorous response to medication related incidents. This is also discussed and additional actions given in Outcome 7: Health and safety and Risk management.

A sample of medication prescription and administration records were reviewed by an inspector. The inspector noted that it could not be demonstrated that medicines were always administered as prescribed due to ambiguous, unclear or inadequate documentation. For example, in one medication administration record, the time of administration was not recorded for a medicine, even though this had been prescribed by the prescriber. Amendments had been made to a medication administration record on two consecutive days and it was not clear if the resident had received the dose of the medicine prescribed. Medication administration records were left blank at times when medicines were due to be administered with no reason recorded on 100% of charts reviewed. Medication related incident forms from the previous inspection in December 2015 also indicated that medicines were not administered as prescribed on 11 occasions such as six occasions where the dose of a medicine was missed, two occasions where a medicine was administered at a frequency greater than that prescribed, one occasion where a dose higher than that prescribed was administered, one occasion where a medicine was administered a time different to that prescribed and one occasion where a medicine was administered that had been previously stopped by the prescriber.

At the time of the inspection, one resident took responsibility for his/her own medicines. Adequate controls and oversight had not been put in place since the previous inspection to ensure compliance and adherence with the resident's medicinal therapy and treatment plan.

Judgment:
Non Compliant - Major
**Outcome 14: Governance and Management**
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Leadership, Governance and Management

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

**Findings:**
At the previous inspection in December 2015, it was identified that it was not clear if preventative actions and learning from reviews of the quality and safety of care and support had been implemented. The proposed timescale outlined in the provider's action plan had not passed and there was little evidence of progress in relation to this finding.

Medicines management audits had not been completed since the previous inspection. The review of the quality and safety of the care and support in the designated centre was not in accordance with the Standards. The audit in relation to staff files did not measure against Standard 7.1. The annual service review completed in December 2015 did not reference the standards.

As outlined in Outcome 07: Health and Safety and Risk Management and the associated action plan, the provider failed to ensure that staff were aware of the procedure to be followed in the case of fire by not having fire drills at recommended intervals. This aspect was found to major non-compliant on inspection in July 2015 but appropriate action had been taken as outlined on inspection in December 2015. The significant findings on this inspection indicated that there are not effective management systems in place to sustain improvement and to ensure the delivery of a safe and consistent service.

**Judgment:**
Non Compliant - Major

**Outcome 17: Workforce**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.
Theme:
Responsive Workforce

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

Findings:
At the previous inspection in December 2015, it was found that the information and documents, as specified in Schedule 2, had not been obtained for all staff based on a sample of staff files reviewed. The proposed timescale outlined in the provider's action plan had not passed and there was evidence of progress in relation to this finding. An inspector reviewed a sample of staff files and found that staff files were not complete. The person in charge had undertaken an audit of 50 staff files. The audit had identified that three staff files could not be found at the centre and, of the 47 files on site, 38 were deemed to be incomplete. In light of the significant failings identified in this audit, the outcome was judged to remain at moderate non-compliant despite the action taken by the provider due to the risk posed to residents by inadequate recruitment procedures demonstrated by incomplete or absent staff files.

At the previous inspection in December 2015, gaps were identified in staff training. The proposed timescale outlined in the provider's action plan had not passed and inspectors found that some progress had been made in relation to this finding. Refresher manual handling training had been provided but six staff members who had commenced employment in December 2015 were yet to receive in-house manual handling training. The person in charge stated that, as this training was provided by external provider, there was no date confirmed for this training.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Louisa Power
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

Centre name: A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland

Centre ID: OSV-0003439

Date of Inspection: 07 January 2016

Date of response: 27 January 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where a close circuit television system was in place, there was not a documented log of when the system was switched on and off to ensure the privacy of the resident was respected especially when personal care was carried out or when visitors were present.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
1. A log for documenting the “turning on and off” of the close circuit television system is now in place.
2. The CNM2/Designate is responsible for monitoring the log and ensuring that it is being correctly used. The log will be included in the daily audits. Any gaps in documentation will be followed up with the staff on duty during these times.

Proposed Timescale:
1. Commenced on the 19th January 2016
2. Commenced 22nd January 2016 and will be ongoing.

Proposed Timescale:

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:
The agreement for the provision of services did not include the support, care and welfare of the resident.

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

Please state the actions you have taken or are planning to take:
Following the Inspection on the 7th January 2016 each agreement has been reviewed. The provision of services is now stated on each individual residents agreement this includes the support, care and welfare of the residents and including the provision of transport and any charges which they incur.

Proposed Timescale: 31/01/2016

Outcome 06: Safe and suitable premises
Theme: Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The external walls of the main house required repainting and the basement kitchenette required upgrading.

3. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
1. The external walls on the main building are limestone and require specialist treatment. Two contractors have reviewed the work and it has been recommended that an engineer assesses the walls as there is water damage which could cause issues when the plaster is being removed. Person in charge to get an engineer to review the walls. A schedule of works to be put in place following this review.
2. The basement works have been prioritised as urgent and the contractor has committed to commence work on the 1st February 2016. In the interim the basement is kept clean and tidy.

Proposed Timescale: 01/04/2016

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 registered provider had not ensured that the risk management policy included the measures and actions in place to control the risks identified.
For example,
- there were gaps in evidence in the documentation for checking of designated fire doors and required door and window closures at night throughout the month of December 2015
- there were gaps in evidence in the documentation of half hourly checks at night for residents who were unable to use a call bell.

4. 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:
1. The Health and Safety Officer is now responsible for carrying out audits of the health and safety checks, including the nightly security checks. Any gaps in documentation are to be brought to the attention of the Person in Charge/PPIM who will follow up with the staff on duty in order to ensure no further omissions occur.
2. The existing system for half hourly checks for residents who are unable to use a call bell has been reviewed. The newly appointed CNM2 is now responsible for carrying out regular audits of all logs and check lists and any evidence of bad practice will be
addressed, followed up and any learning will be shared amongst the staff teams and with management.

3. A national learning log will be rolled out in early 2016 to ensure learning across all services in the area of risk management/clinical risk management. The information gathered locally through auditing in the service will be communicated into the national learning log.

Proposed Timescale:
2. Commenced – 22nd January 2016
3. 31st March 2016

### Proposed Timescale:

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The arrangements in place for investigating and learning from medication related incidents were not robust, the repetitive nature of this risk had not been adequately assessed and timely steps had not been taken to minimise the potential harm.

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

**Please state the actions you have taken or are planning to take:**
1. Following the inspection on the 7th January 2016 an immediate action plan regarding medication has been developed for identifying, recording, investigating and learning from adverse incidents. This includes a more robust and frequent auditing of medication management and the management of medication errors and will include daily and weekly audits.
2. All staff that plays a role in the dispensing of medication will be spoken to about the importance of getting all elements of medication management correct and the potential impact of errors has on the safety of the residents.
3. A support and training plan is being developed in order to retrain and reassess any employee who makes repeated medication errors.
4. Going forward all employees who have responsibility for the administration of medication will have an annual performance appraisal which will include the reviewing of knowledge, skills and competencies in relation to managing and administering medicines.
5. A national learning log will be rolled out in early 2016 to ensure learning across all services in the area of risk management/clinical risk management. The information gathered locally through auditing in the service will be communicated into the national learning log.
Proposed Timescale:
1. 22nd January 2016
2. 14th February 2016
3. 14th February 2016
4. 31st March 2016
5. 31st March 2016

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

   **Please state the actions you have taken or are planning to take:**
   A fire drill has been carried out in the centre on 08/01/2016 at 11:44.
   A plan of action regarding regular fire drills has been developed. This includes the carrying out of on-site training for fire wardens so as to ensure we are learning from the issues that have arisen in previous fire drills.
   A schedule of drills will be put in place for the next 18 months to ensure that all fire wardens participate in a fire drill.

Proposed Timescale: **08/01/2016**

**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:**
A staff member was yet to attend training in the management of behaviour that is challenging including de-escalation and intervention techniques.

7. **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:
All staff are now trained in the management of behaviour that is challenging including de-escalation and intervention techniques

**Proposed Timescale:** 12/01/2016

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The part of the personal plan that related to health did not always reflect the assessed needs of residents and was not updated when the assessed needs changed.

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

Please state the actions you have taken or are planning to take:
1. Three personal plans will be audited weekly to ensure that all documentation is up to date, complete and any gaps in care are identified. Assessments will be updated as they form the basis of the personal plans.
2. All personal plans will be person centred, live and will address the needs of the resident and any potential risks/problems.
3. Evaluation of audit and action plan to be passed on to the Named Nurse with a date when the Personal Plan will be revisited by CNM2.
4. Named CNM to support Named Nurse, CSW and Community Integration team to implement Action Plan. CNM2 to re-audit Personal Plan to ensure Action plan is implemented.
5. Process to continue every week as residents needs will change and to maintain a robust documentation system.

**Proposed Timescale:** 11/01/2016

**Outcome 12. Medication Management**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It could not be demonstrated that medicines were always administered as prescribed due to ambiguous, unclear or inadequate documentation.

Medication related incident forms from the previous inspection in December 2015 indicated that medicines were not administered as prescribed on 11 occasions.
9. **Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
1. Following the inspection on the 7th January 2016 an immediate action plan regarding medication has been developed for identifying, recording, investigating and learning from adverse incidents. This includes a more robust and frequent auditing of medication management and the management of medication errors. It also includes a review of the manner in which the medication is being documented; for example the sheets for recording the medication and the MARS.
2. All staff that plays a role in the dispensing of medication will be spoken to about the importance of getting all elements of medication management correct and the potential impact of errors has on the safety of the residents.
3. A support and training plan is being developed in order to retrain and reassess any employee who makes repeated medication errors.
4. Going forward all employees who have responsibility for the administration of medication will have an annual performance appraisal which will include the reviewing of knowledge, skills and competencies in relation to managing and administering medicines.
5. A national learning log will be rolled out in early 2016 to ensure learning across all services in the area of risk management/clinical risk management. The information gathered locally through auditing in the service will be communicated into the national learning log.

**Proposed Timescale:**
1. 22nd January 2016
2. 14th February 2016
3. 14th February 2016
4. 31st March 2016
5. 31st March 2016

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**Proposed Timescale:**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
For residents who took responsibility for their own medicines, adequate controls and oversight had not been put in place to ensure compliance and adherence with the resident's medicinal therapy and treatment plan.

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

Please state the actions you have taken or are planning to take:
1. Following the inspection on the 7th January 2016 an immediate action plan regarding
medication has been developed for identifying, recording, investigating and learning
from adverse incidents. This includes a more robust and frequent auditing of
medication management and the management of medication errors including reviewing
any resident who takes responsibility for their own medication.
2. All staff that plays a role in the dispensing of medication will be spoken to about the
importance of getting all elements of medication management correct and the potential
impact of errors has on the safety of the residents.
3. An individual risk assessment has been completed for all residents who are self-
medicating.
4. Each resident’s care plan is currently being updated to include the level of support
that they each require.
5. As part of the current review of all of the medication management policies and
procedures within the organisation a system for monitoring whether the resident is still
able to self-administer medicines will be included in their care plans which will also
detail the ongoing supervision to ensure adherence with the treatment plan.

Proposed Timescale:
1. 22nd January 2016
2. 14th February 2016
3. 14th February 2016
4. 31st March 2016
5. 31st March 2016

Proposed Timescale:

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 review of the quality and safety of the care and support in the designated centre
was not in accordance with the Standards.

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

Please state the actions you have taken or are planning to take:
1. Cheshire Ireland has established a team of auditors external to the service who will
carry out bi-annual audits of the quality and safety of care and support in each
designated centre.
2. Following the inspection on the 7th January 2016, a review of the current management and auditing system has been undertaken. The new and improved audit includes the dissemination of the learning from the audits so as to ensure the same incidents do not reoccur and services improve.

**Proposed Timescale:** 31/03/2016  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
There are not effective management systems in place to sustain improvement and to ensure the delivery of a safe and consistent service.

12. **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:  
Following the inspection on the 7th January 2016 a more robust auditing system shall be put in place in order to sustain improvement in the area quality and safety in the centre. This will include audits in the following areas:

- Medication Management, Adverse Events, Complaints, Health and Safety, HSE environmental checks, Annual Reviews and HSE Infection Control Audits.

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

**Outcome 17: Workforce**  
**Theme:** Responsive Workforce

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

13. **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:  
1. An audit of all personnel files has now been completed.
2. Areas in the files where gaps have been identified are being followed up.
3. All necessary information regarding Schedule 2 will present on the files going
**Proposed Timescale: 15/02/2016**

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Six staff members who had commenced employment in December 2015 were yet to receive in-house manual handling training.

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

Please state the actions you have taken or are planning to take:
1. All frontline staff are trained in manual handling; 6 staff members who commenced in December 2015 did not possess the Cheshire Ireland in-house training. 3 of these staff have since been trained.
2. 3 remaining staff to be trained in the Cheshire Ireland Training in February 2016

Proposed Timescale:
1. 22nd January 2016
2. 28th February 2016

**Proposed Timescale:**