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

### Centre ID:
OSV-0003445

### Centre county:
Galway

### Type of centre:
Health Act 2004 Section 39 Assistance

### Registered provider:
The Cheshire Foundation in Ireland

### Provider Nominee:
Mark Blake-Knox

### Lead inspector:
Ann-Marie O'Neill

### Support inspector(s):
Lorraine Egan

### Type of inspection:
Unannounced

### Number of residents on the date of inspection:
9

### Number of vacancies on the date of inspection:
1
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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
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<tr>
<td>10 November 2015 10:40</td>
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<td>11 November 2015 10:00</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>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 03: Family and personal relationships and links with the community</td>
</tr>
<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
</tr>
<tr>
<td>Outcome 05: Social Care Needs</td>
</tr>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 10. General Welfare and Development</td>
</tr>
<tr>
<td>Outcome 11. Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 13: Statement of Purpose</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 16: Use of Resources</td>
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<tr>
<td>Outcome 17: Workforce</td>
</tr>
<tr>
<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection

This report sets out the findings of a follow up inspection following a previous inspection which had identified high levels of non compliance carried out August 2015. The focus of this inspection was to assess the provider's response to non compliances found previously. Overall, inspectors found there had been a number of improvements across all Outcomes. Since the previous inspection the provider had implemented appropriate fire management systems to address previous risks identified. The inspectors identified noticeable improvement in the cleanliness of the centre. Residents told inspectors they were very happy with the improvements to their living spaces.

In an effort to improve security arrangements in the centre, the provider had changed doors and windows in all ten residential units. Residents spoken with all mentioned how this had greatly improved the warmth in their residential units. The
new windows and doors also added to the overall visual aesthetic of each residence.

Actions related to Governance & Management had brought about improved governance and supervision practices in the centre. The provider had increased the hours of the care co-ordinator from 20 to 30 hours per week. They had also developed a new role of social support worker, whose role included the oversight of residents' social care needs and development of social care plans based on residents' interests and goals. At the time of inspection both the care co-ordinator and social support worker were working in their newly designated roles with increased hours. Inspectors found greater compliance throughout most Outcomes on this inspection due to the more robust management and supervision arrangements.

However, both roles were not permanent positions and were only funded to the end of 2015 which concerned inspectors as overall compliance for the centre would not be sustainable without the enhanced governance arrangements. Inspectors brought these concerns to the provider nominee during the course of the inspection. The provider nominee confirmed before the close of the inspection that both roles would be made permanent and forwarded on an email to confirm this to the lead inspector in order to provide assurances.

Additional components of Outcome 14; Governance and Management remained non compliant. The provider had not carried out six monthly unannounced audits or annual review since regulation commencement November 2013. At the time of this inspection a review of the quality audit system within Cheshire Ireland was underway. A working group had been appointed and the first meeting had been held 22 July 2015. The provider had scheduled an unannounced visit to the centre before the end of 2015. At the time of the inspection the unannounced audit had not occurred. Also an annual review of the service provided in the centre had not been completed.

During previous inspections of the centre, inspectors had been concerned in relation to healthcare outcomes for residents and the lack of allocated nursing hours (10 hours per week) designated to meet residents' healthcare needs. To address this the provider had increased the number of hours the care co-ordinator (nurse) worked in the centre. This was found to have enhanced the oversight of resident's clinical health care needs and provided the care co-ordinator time to supervise support staff to ensure they carried out health care interventions in line with residents' care plans and best practice.

Four Outcomes met with moderate non compliance, Residents Rights, Dignity & Consultation in relation to the complaints procedure and policy for the centre, Governance & Management in relation to matters set out previously, Workforce, not all staff had received training in abuse prevention & detection and Records & Documentation, in relation to continued non compliance related to lack of policies as required in Schedule 5 of the Regulations.

The findings of this inspection are set out in this report with actions and the provider's response at the end of the report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
On the previous inspection there were a number of non compliances in this outcome. Inspectors found that most had been addressed. However, there were some improvements still required in relation to the complaints policy and procedures for the centre.

The private residential area of the designated centre had been re-painted which made it visually distinctive from the rest of the centre. Larger more prominent signage was in place also. This would further alert visitors to the centre that they were entering a private residential area. All residents spoken with had been consulted with regarding the re-decoration, style and colour of their individual residential units. Residents had been given the opportunity to decorate in line with their personal preferences and taste.

The previous inspection identified a lack of meaningful activities for residents with significant physical disabilities. Inspectors found on this inspection that individual social care plans were being developed, with residents leading the development of these plans in conjunction with the social support worker.

Inspectors spoke with the social support worker during the inspection in relation to social care plans she was developing. Work was still in progress to ensure all residents had a programme in place. The plans that had been completed were comprehensive, detailed and person centred in line with residents goals and interests. This is further discussed in Outcome 5; Social Care Needs.
Inspectors were satisfied that all residents in the centre would, regardless of extent of their physical disabilities, have a comprehensive activity plan in line with their interests and abilities within the timeline set out by the provider, 30 November 2015.

The centre specific complaints procedure had been revised and now included the name and contact details of the person nominated for individuals to contact if they had a complaint. The person nominated was the person in charge. The complaints procedure was displayed in a number of areas within the designated centre in prominent places. Notable was the improved layout of the complaints procedure which meant it was in a more accessible/easy read format.

An information pack was being developed which contained a resident's guide to the centre, the complaints policy and procedure, contact details and information on advocacy persons, for example. This would address the non compliance found on the previous inspection whereby inspectors were not satisfied that residents, their family or visitors had access to information on how to make a complaint. Cheshire Ireland’s national learning and development manager had also produced an audio version of the complaints procedure for residents who required it.

While the complaints policy identified the regional manager and regional service quality officer would review complaints every three months to ensure organisational learning, it did not identify either of them as the nominated person, other than the person nominated in Regulation 34(2)(a).

Furthermore, the complaints process did not outline residents could appeal the findings of an investigation into their complaint at any stage but rather when the complaint investigation had been completed or at Stage 5 as outlined in the policy. This did not demonstrate that residents had access to a fair and transparent appeals process. The appeals process did not meet the matters as set out in regulation 34(1).

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Residents now had access to suitable communal space to suit their needs and requirements. Previously the room had been made available to external groups used to
hold classes which were not suitable for residents to join in with, such as pregnancy yoga and Mother and baby groups. These classes were no longer occurring in the room.

The provider had commenced a refurbishment of the space in line with the wishes of the residents and some enhancements made had already improved the aesthetic quality of the space. The room had been freshly painted and the introduction of a recliner couch and flat screen TV made it a more comfortable space that residents had the option of benefiting from as they wished. Residents spoken with during the inspection said they liked the changes made to the room and inspectors observed a resident meeting a visitor in the space during the course of the inspection.

Individual personal plans had been reviewed with residents. Social care plans identified residents' wishes with regard to their activities and interests, relationships and goals. The plans were developed by the social supports facilitator and would be reviewed six-weekly to evaluate and measure for effectiveness. From the sample of plans reviewed during inspection some goals indicated residents' wishes to maintain or re-establish their relationships with their family were discussed and strategies were in place or being developed to enable residents actualise those goals.

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

**Findings:**
Inspectors reviewed a sample of revised contracts of care which outlined the services provided and a space where residents' individual fees would be entered. The provider had also drafted an easy read information leaflet regarding payment of rental fees. It outlined the set rent for a single person and/or couple. It also detailed how residents could pay their rental fee, what happens if resident has difficulty paying the fee and information on rental supplement and details of where to contact for information.

At the time of inspection the timeline for completion of this action had not passed. The date agreed had been set for 30 November 2015. The person in charge assured residents that contracts would be given to residents for signing by the set timeline date.
Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
A number of non compliances were found in this Outcome during the previous inspection. On this inspection, inspectors identified improvements had occurred and actions plan responses made by the provider to address them were underway or completed.

Secure storage units had been fitted in all residents’ residential units. These would allow residents to now have access to their personal plans but also ensure their privacy was maintained.

The social support worker outlined to inspectors the revised social care assessment each resident was participating in. Previously inspectors had found residents’ assessments of need were based on outcome from a ‘best possible health’ assessment. The social care assessment had now been expanded to included sections such as ‘interests and activities’ and ‘relationships and personal goals’.

Personal plans also included a more comprehensive health care assessment which identified residents' person specific health care needs to which each had a detailed nursing care plan outlining evidence based health care interventions, review dates and information related to allied health professional reviews and recommendations.

All social care plans reviewed during the inspection had identified goals, information on how those goals would be achieved and review dates. This would ensure residents progress towards achieving their goals could be identified during the six weekly reviews which had been identified as the review time frame in the response by the provider. Review of residents’ personal plans would be undertaken by the person in charge in conjunction with the social support worker and/or care co-ordinator as appropriate.

Previously social or health care plans had a line drawn through them, a date and a
signature when they were reviewed. They did not indicate if a goal was achieved or why the plan was discontinued. The provider had sought to address this non compliance by creating a new care planning system with an improved template. They now incorporated sections whereby the reviewer documented progress made, any changes made to the plan, their signature, the date and the next review date.

From the sample of social care plans reviewed there had been a significant improvement in the level of detail they captured which reflected the interests, goals and dreams of each resident. Previously some social care plans for residents had been one line. Social care plans now consisted of a number of documented pages with an eclectic array of goals across a wide range of areas. There was evidence to now indicate that social care plans for residents had a focus on maximising residents' personal development and/or life skills.

**Judgment:**
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:**
On previous inspections, inspectors found the centre and residents’ individual living units were not homely. There had been varying standards of cleanliness and decor from one residential unit to another and the communal day room was not used by residents in any meaningful way, it was an uninviting space which required refurbishment and redecoration.

The provider had undertaken to address the actions of the previous inspection. These included the following:

- All residential units had been re-painted and decorated in line with residents preferences and taste.
- A cleaning schedule had been established whereby each resident was offered to have their residential unit given an overall clean by the designated maintenance personnel.
- A documented record was now maintained by the maintenance person that identified what areas had been cleaned in each residential unit.
- Care staff working in the centre implemented a 'clean as you go' policy. Where they identified specific areas that required deeper cleaning they would bring them to the attention of the cleaner.
- The communal day room had been re-painted and some soft furnishings in the room had been introduced for example, a recliner couch and armchair, a lamp and flat screen TV.

Overall, inspectors observed a noticeable improvement in the cleanliness of the centre. Residents told inspectors they were very happy with the improvements to their living spaces.

In an effort to improve security arrangements in the centre, the provider had changed doors and windows in all ten residential units. Residents spoken with all mentioned how this had greatly improved the warmth in their residential units. One resident mentioned they were no longer cold in the night time and didn't need a plug in heater anymore. The new windows and doors also added to the overall visual aesthetic of each residence.

Storage options in the centre were still limited however. Inspectors did note that residents' personal assistive equipment was no longer stored in residents' ensuite shower rooms. The person in charge also informed inspectors that they were reviewing storage options within the centre whereby residents’ assistive equipment which was in line with the provider's action plan response and timeline.

While there had been improvements overall in this Outcome, inspectors were still not satisfied that the communal room had been refurbished to its full potential and there was still more work to do in order to ensure it met the needs of all residents. The regional manager informed inspectors that there was a plan to replace the carpeted floor in the room with a wooden one. During the inspection he was given verbal agreement by the provider that this change had been sanctioned.

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

**Findings:**
All actions from the previous inspection had related to fire non compliance issues. Since the previous inspection the provider had implemented a suite of works which inspectors found had been completed at the time of inspection.
Works completed included:

- Existing heat seals to residential unit, kitchen and staff canteen doors had been replaced with heat/smoke seals and doors had been provided with a 'free swing' self closing device which was connected to the fire alarm with a test release button.

- In the laundry, sluice, physiotherapy and office rooms existing heat seals had been replaced with heat/smoke seals and provided with overhead self closing devices.

- A new fire compliant door and dividing screen had been installed in the corridor leading to the residential units of the centre. This would provide enhanced fire containment and protection to the building. These doors had a 60 minute fire rating and fire rated glazing, they were connected to the fire alarm system also.

- The attic space over the residential wing of the premises and space over the office had been provided with a new 60 minute compartment wall to prevent the unseen spread of fire. A fire seal of all service penetrations of the attic ceiling had been installed in areas such as over the hot press and residential units.

- All existing ironmongery and locks from doors had been removed and replaced with fire compliant options to enhance provisions for evacuation in the event of an emergency.

- A flame retardant paint and varnish had been applied to the overhead timber joists located in the communal room of the centre.

- Emergency lighting had been installed in each residential unit which were linked to the fire alarm so that they would turn on in the event of the alarm activated.

Inspectors also found evidence that daily and weekly fire checks in place were now recorded as completed. The daily and weekly checks were now centre specific and no longer generic and took account of site specific arrangements. There were now appropriate records being maintained of the fire alarm and emergency lighting maintenance.

The evacuation procedure for the centre had been revised and was now centre specific. Personal evacuation plans had been updated to contain sufficient detail as to the evacuation needs of the residents. Fire drills had occurred and there was an ongoing schedule of drills planned to ensure all residents and staff in the centre were aware of evacuation procedures in the centre.

Judgment:
Compliant

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:**
Previously inspectors had not been assured there were adequate measures implemented to ensure incidents of abuse would not go unreported. Responses to interviews held with the management team of the centre related to safeguarding and safety had not provided evidence that there were sufficiently robust measures in place to protect residents.

Since then the provider had instigated a number of measures to address these non compliances. Adult protection and safeguarding training had been provided to all staff on the 29 September 2015. The person in charge had met with all staff individually and reviewed their knowledge of safeguarding procedures and responses in line with the organisations policy. The topic of safeguarding had been introduced as a running theme at all staff team meetings.

Further measures had also been implemented to ensure residents had opportunities to raise concerns and understand their rights and knowledge of how to access advocacy services. The regional manager (PPIM) had met with each resident to ensure they could give him feedback in relation to the service and care they were receiving.

An adult protection and safeguarding session on residents’ right to feel safe and be protected was scheduled for 11 November 2015. Inspectors saw documented invitations which inviting residents to attend this session which would be held in the communal day room of the centre. Residents that did not wish to participate in a group would have the opportunity to avail of an individual meeting with the person carrying out the session. The provider stated in their action plan response that safeguarding and the right to feel safe session would be held annually and new residents to the centre would receive the opportunity to have training also.

The provider had acquired the services of an external agency to carry out an investigation into allegations of abuse which had been made against staff working in the centre. At the time of inspection the investigation was going through due process.

A new colourful large print residents' charter of rights for people who use Cheshire services, was located on the corridor which led to residents' residential units. It outlined seven tenants of rights for all residents living in the centre, the first of which said, residents had 'the right to a safe environment, and to be free from abuse of any kind'.

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### Outcome 10. General Welfare and Development

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

**Findings:**
As outlined in Outcome 5 substantial improvements had been made to address non compliances found in relation to residents’ inadequate assessment and supports in place to meet their social care needs.

Inspectors found on this inspection that comprehensive assessments underway by the social support facilitator identified comprehensive and varied goals residents wished to achieve. From the sample of personal plans reviewed residents' general welfare and development needs had been identified and goals set. Some residents spoken with during the course of inspection informed inspectors that they had expressed an interest in training in self advocacy.

Some residents spoken with indicated they would like to change their job of which they had worked in some instances for 15 years or more. They told inspectors they felt they had more opportunities now and could be supported to make changes so as to achieve greater job satisfaction and develop their potential.

**Judgment:**
Compliant

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### Outcome 11. Healthcare Needs

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

**Theme:**
Health and Development

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

Findings:
Over previous inspections of the centre, inspectors had been consistently concerned in relation to healthcare outcomes for residents and the lack of allocated nursing hours (10 hours per week) designated to meet residents' healthcare needs.
A number of actions had been given in this Outcome on the previous inspection and the provider's action plan to address them was reviewed on this inspection.

The provider had increased the number of hours the care co-ordinator (nurse) worked in the centre. These had increased from 10 hours per week to 30 hours which was spread over seven days over the morning, afternoon and evening. This would ensure better oversight of resident's clinical health care needs and provide the care co-ordinator time to supervise support staff to ensure they carried out health care interventions in line with residents' care plans and best practice.

Since the previous inspection, the care co-ordinator had revised almost all residents’ health care plans. The time line date for completion was the 30 November 2015. Inspectors spoke with the care co-ordinator and she explained the improvements she had made to residents plans since the previous inspection to address non compliances found.

Individual healthcare needs for residents had been identified by the care co-ordinator and incorporated into a comprehensive health care plan for each resident with associated health care risk assessments where appropriate. Review dates for care plans had been established and would occur every six weeks or more often if necessary.

The nutritional requirements for residents were now being monitored in consultation with community dietician services. A nutritional risk assessment tool had been introduced which would ensure resident's nutritional risk was regularly monitored and identified early which would result in better health care outcomes for residents and intervention by dietetic services where required. Residents weights were up to date and an associated Body Mass Index (BMI) was calculated also to enhance detection of nutritional risk.

Residents receiving nutrition through percutaneous endoscopic gastrostomy feeding(PEG) had been reviewed by a dietician. Following dietetic review changes had been made to some resident's nutritional prescription to ensure they could maintain a healthy weight. As part of some nutritional care plans for residents blood tests were ordered and would be monitored regularly going forward to ensure their nutritional prescription met their needs. This was evidence of improved and comprehensive nutritional health care for a resident.

Many residents in the centre were assessed as being at high risk of developing pressure ulcers due to their physical disability. On the previous inspection, inspectors were concerned that residents’ pressure ulcer risk was not being assessed and measures in place to prevent skin breakdown were not being adequately implemented, staff did not demonstrate knowledge of how to use some electronic pressure relieving equipment. On this inspection, inspectors found improvements in relation to this had occurred.
Residents had received a risk assessment relating to pressure ulcers which could identify their level of risk. An associated care plan was in place for residents identified at risk of developing pressure ulcers. An inspector reviewed the electronic mattress in place for one resident and found it had been set at the correct pressure level relative to their assessed weight. The care co-ordinator had held an informal training session with staff to enhance their understanding of pressure ulcer prevention and detection. She was also due to attend wound management training on the 13 November 2015 and information she learned at this training would be given to staff.

At the time of inspection six of the nine residents had received a dental appointment and check up. Of the other residents dental appointments had been scheduled and one resident had refused to attend. Some residents had been recommended extractions based on the check up they received. The care co-ordinator was liaising with the resident and their dentist to ensure the residents requiring treatment were being supported.

**Judgment:**
Compliant

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

**Findings:**
The statement of purpose contained most of the matters as set out in Schedule 1 of the Care and Welfare Regulations, however, it had not been updated to reflect the change in working hours of some staff working in the centre, for example, the care coordinator now worked 30 hours per week but the statement of purpose mentioned 20 hours. Therefore, the whole time equivalent numbers for the centre were inaccurate.

It also outlined the governance structures for the centre however, it did not identify what role each person was designated in line with the regulations, for example, person in charge, or person participating in management.

Changes had been made to how residents health care needs were assessed for example, the statement of purpose required review to ensure the improved changes were reflected.
Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall, inspectors found that actions from the previous inspection had been completed or were in progress to meet the timelines as set out by the provider. Governance at a local level in the centre had improved. The person in charge had instigated structured supervision meetings with care staff working in the centre. These had started and were planned to take place every eight weeks. Meetings were documented.

In instances where residents were in receipt of shared services, where residents received a service from Cheshire Ireland and also received support from an external provider, the service would now be reviewed by the person in charge in collaboration with the resident. This would ensure residents received support in raising any issues they may have. Meetings with residents and person in charge had occurred.

The area manager had also met with residents to receive their feedback on the service they were receiving. Quarterly meetings had been established between the provider and all external service providers. These meetings provided a forum whereby issues of concern or feedback could be raised on behalf of residents and addressed if required.

During the previous inspection, inspectors were not assured that staff could raise concerns about the quality and safety of care and support provided to residents. To address this action the provider had ensured all staff attended training in dignity at work on 30 September 2015. Structured supervision sessions, as mentioned previously were another way in which the provider and person in charge would provide staff with an opportunity to raise concerns or issues.

Previous inspections had found consistent failures by the provider to ensure there were adequate supervision and management systems to support the person in charge. On
this inspection, more robust governance and management systems were in place. The recently established care co-ordinator role hours had increased from 20 to 30 hours which was provided over seven days per week morning and evening. This ensured greater oversight and supervision of staff and care practices in the centre on a consistent basis.

The provider had also commenced a recruitment drive for an additional position of senior care support worker who would work in the centre for 20 hours. This would also provide additional support to the person in charge to ensure residents' social care needs were continuously monitored and reviewed. At the time of inspection both the care co-ordinator and social support worker were working in their newly designated roles with increased hours. Inspectors found greater compliance throughout most Outcomes on this inspection due to the more robust management and supervision arrangements.

However, both roles were not permanent positions and were only funded to the end of 2015 which concerned inspectors as overall compliance for the centre would not be sustainable without the enhanced governance arrangements. Inspectors brought these concerns to the provider nominee during the course of the inspection. The provider nominee confirmed, before the close of the inspection, that both roles would be made permanent and forwarded on an email to confirm this to the lead inspector in order to provide assurances. However, at the time of this report the provider had not submitted a notification to the Chief Inspector notifying of the appointment of the care co-ordinator in a person participating in management role.

On previous inspections consistent non compliance was found in relation to the lack of auditing of the centre to monitor the quality and safety of care provided to residents. The provider had not carried out six monthly unannounced audits or an annual review since regulation commencement November 2013.

At the time of this inspection a review of the quality audit system within Cheshire Ireland was underway. A working group had been appointed and the first meeting had been held 22 July 2015. The provider had scheduled an unannounced visit to the centre before the end of 2015. At the time of the inspection the unannounced audit had not occurred. Also an annual review of the service provided in the centre had not been completed.

Judgment:
Non Compliant - Moderate

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

Findings:
The centre was still not resourced with weighing scales which could meet the needs of residents. At the time of inspection, a hoist with incorporated weighing scales was being transported from another centre in north Mayo in order to weigh residents in the centre and while this ensured residents were now being weighed, the centre was still not adequately resourced to meet the needs of residents in relation to nutrition assessment and management.

Judgment:
Substantially 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 provider had increased the nursing care provision in the centre from 20 to 30 hours. Inspectors found an improvement in the quality and monitoring of residents clinical care needs which had a positive impact on their care and welfare.

Previously staff file reviewed had not contained some of the matters as set out in Schedule 2 of the Regulations. This had not yet been addressed on this inspection. The person in charge informed inspectors that this action was still in progress and all files were being reviewed. The timeline completion date for this action was 30 November 2015 had not passed at the time of the inspection.

Staff had received training in a human rights approach to adult protection and safeguarding. Staff spoken with said they had enjoyed it and it gave them an opportunity to reflect and ask questions. Items covered during the training included restraint, legislation and human rights. However, the care co-ordinator and social support worker had not received this training both of which were in supervisory roles within the centre.
Previously staff working in the centre failed to demonstrate adequate knowledge in how to operate electronic pressure relieving equipment. On this inspection, staff spoken with were knowledgeable and had been shown how to operate equipment by the care co-ordinator.

Food safety training for relevant staff was scheduled for 25 of November 2015 and would be within the timeframe agreed in the action plan for the previous August 2015 inspection report.

**Judgment:**
Non Compliant - Moderate

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**Outcome 18: Records and documentation**

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Theme:**
Use of Information

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

**Findings:**
A directory of residents was now in place and up to date.

At the time of inspection all Schedule 5 policies were still not in place. In some instances policies were not centre specific and had 'name of centre' documented which could be deleted and the name of the centre inserted.

Previously there had been no formal system to ensure staff had read and understood policies in place. At the time of inspection, the person in charge could not provide inspectors evidence that staff had read policies. She informed inspectors that she had asked staff to read them at their one to one supervision sessions. In most instances policies had only a few signatures indicating the staff that had read them.

Schedule 5 policies were still not readily available in the centre with some not in the designated folder and others in electronic format. This action had not been adequately completed within the timeline identified in the August 2015 report action plan response.
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:

Ann-Marie O’Neill
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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003445</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>10 November 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>21 December 2015</td>
</tr>
</tbody>
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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:
While the complaints policy identified the regional manager and regional service quality officer would review complaints every three months to ensure organisational learning, it did not identify either of them as the nominated person, other than the person nominated in Regulation 34(2)(a).

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

**Please state the actions you have taken or are planning to take:**
The PPIM has been identified as the second nominated person in the service for response to and management of complaints. This information is displayed in easy to read format in visible locations in the centre.

**Proposed Timescale:** 21/12/2015

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints process did not outline residents could appeal the findings of an investigation into their complaint at any stage but rather when the complaint investigation had been completed or at Stage 5 as outlined in the policy. This did not demonstrate that residents had access to a fair and transparent appeals process.

2. **Action Required:**
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
A localised Appeals Process has been designed and distributed to all residents. This process is prominently displayed alongside the Complaints Process in both the public area and the residential corridor.

**Proposed Timescale:** 10/12/2015

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At the time of inspection, the communal space still did not provide residents with an inviting comfortable space for all residents to use.

3. **Action Required:**
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.
Please state the actions you have taken or are planning to take:
This space has been refurbished, a new floor has been fitted, and soft furnishings are in place. Final pieces of décor are pending completion.

Proposed Timescale: 10/01/2016

Outcome 13: Statement of Purpose
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The whole time equivalent numbers for the centre were inaccurate.

The statement of purpose did not identify what role each person was designated in line with the regulations, for example, person in charge, or person participating in management.

Changes had been made to how residents health care needs were assessed for example, the statement of purpose required review to ensure the improved changes were reflected.

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

Please state the actions you have taken or are planning to take:
The Statement of Purpose has been amended and updated to reflect changes, a copy has been submitted to the Authority.

Proposed Timescale: 03/12/2015

Outcome 14: Governance and Management
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At the time of this report the provider had not submitted a notification to the Chief Inspector notifying of the appointment of the care co-ordinator in a person participating in management role. A non compliance for this is given in Outcome 9; Notifications.

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

Please state the actions you have taken or are planning to take:
The provider has submitted a notification to the Chief Inspector notifying of the appointment of the Care Co-ordinator in a Person Participating in Management role.

**Proposed Timescale:** 02/12/2015  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following regard:
The provider had scheduled an unannounced visit to the centre before the end of 2015. At the time of the inspection the unannounced audit had not occurred.

6. **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:
An unannounced audit was carried out in the service on 16th & 17th December 2015. The report on this audit is pending.

**Proposed Timescale:** 10/01/2016  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following regard:
At the time of inspection an annual review of the service provided in the centre had not been completed.

7. **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:
An annual service review of the service has been completed, the review is comprehensive and considered a range of areas such as, individual & family consultations, service delivery, care plans, complaints review, adverse events reports. A report of same is being developed.
Proposed Timescale: 31/12/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was still not resourced with a weighing scales which could meet the needs of residents.

8. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
An appropriate weighing scales has been ordered for the service and is expected to be on site before 15.01.2016.

Proposed Timescale: 15/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The care co-ordinator and social support worker had not received training in vulnerable adult safeguarding both of which were in supervisory roles within the centre.

9. 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:
Both staff are scheduled to attend Adult Protection Training in January 2016.

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:
At the time of inspection all Schedule 5 policies were still not in place.

10. **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:**
All Schedule 5 Policies are in place and available in printed format. All staff are currently in the process of reading and signing all policies.

**Proposed Timescale:** 31/12/2015

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At the time of inspection, the person in charge could not provide inspectors evidence that staff had read policies. She informed inspectors that she had asked staff to read them at their one to one supervision sessions. In most instances policies had only a few signatures indicating the staff that had read them.

Schedule 5 policies were still not readily available in the centre with some not in the designated folder and others in electronic format. This action had not been adequately completed within the timeline identified in the August 2015 report action plan response by the provider.

11. **Action Required:**
Under Regulation 04 (2) you are required to: Make the written policies and procedures as 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 available to staff.

**Please state the actions you have taken or are planning to take:**
All Schedule 5 polices are available and are in printed format, all staff are currently in the process of reading all policies and signing to confirm same. Schedule 5 policies are discussed at Team Meetings and the Person in Charge is conducting ongoing reviews of staff having read & signed these policies.

**Proposed Timescale:** 31/12/2015

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In some instances policies were not centre specific and had 'name of centre' documented which could be deleted and the name of the centre inserted.

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

*Please state the actions you have taken or are planning to take:*
Policies are under review and are will be individualised so as to be centre specific.

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