<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland</th>
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<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0003441</td>
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<td><strong>Centre county:</strong></td>
<td>Dublin 20</td>
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<tr>
<td><strong>Type of centre:</strong></td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td><strong>Registered provider:</strong></td>
<td>The Cheshire Foundation in Ireland</td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Mark Blake-Knox</td>
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<tr>
<td><strong>Lead inspector:</strong></td>
<td>Conor Brady</td>
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<td><strong>Support inspector(s):</strong></td>
<td>Caroline Vahey</td>
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<tr>
<td><strong>Type of inspection</strong></td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
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<td><strong>Number of vacancies on the date of inspection:</strong></td>
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About monitoring of compliance

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

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

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards

▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge

▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

The inspection took place over the following dates and times
From: 26 May 2016 09:30
To: 26 May 2016 18:30

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 05: Social Care Needs</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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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection
Background to the inspection
This unannounced inspection was carried out to monitor compliance with specific outcomes and follow up on actions issued on the previous inspection. This was the fifth inspection of this designated centre since the commencement of the regulatory process in disability services in November 2013.

The previous inspection of this designated centre took place on 4 November 2015. Some of the actions highlighted in the previous inspection had been not been satisfactorily addressed. This inspection took place as a result of specific notifications received by HIQA regarding resident's health care needs.

How we gathered our evidence
As part of the inspection, the inspectors met with many of the residents who resided in the centre. Some of the residents spoke to inspectors and other residents communicated on their own terms and in their own way with inspectors. Inspectors met the clinical nurse manager (CNM) and a member of the regional management team who attended preliminary feedback following this inspection. The inspectors spoke with and observed the practice of staff members. The inspectors observed practices and reviewed documentation such as personal support plans,
medical/healthcare records, incidents and accidents, risk assessments, rosters, complaints, notifications, training records and policies and procedures.

Description of the service
The provider had a statement of purpose in place that explained the service they provided. There were 15 people living in the centre (8 females and 7 males). The age range of the residents varied between 33 years old and 73 years old. The designated centre' statement of purpose indicated that the service supported people with a variety of disabilities including the following: Cerebral Palsy; Multiple Sclerosis; Hydrocephalus; Acquired Brain Injury; and Cerebrovascular accident. Often people attending the service have secondary disabilities which could include an intellectual disability, mental health difficulties or medical complications such as diabetes. Many of the people accessing this service have high physical support needs and require supports to enable each person to maintain the best possible health and to remain as independent as possible, for as long as possible.

Overall judgment of our findings
Overall, the inspectors found very poor levels of compliance with the Regulations and Standards based on the findings of this inspection. Some issues identified on the previous inspection had not been satisfactorily addressed by the provider. For example, the appropriate provision of healthcare in the centre on an on-going basis in line with residents needs was not found to be adequate.

The inspectors found non compliance in all outcomes inspected on this unannounced inspection.

The inspectors also found areas that required substantive improvements in accordance with the Regulations and Standards. These areas included:
- Residents' Rights, Dignity and Consultation (Outcome 1) - Improvements were required regarding residents' rights and privacy needs.
- Admission and Contract for the Provision of Services (Outcome 4) - Improvements were required in the contracts for provision of services.
- Social Care Needs (Outcome 5) - Improvements were required in the standard of personal planning, social care provision and social goal/objective setting with residents
- Health, Safety and Risk Management (Outcome 7) - Improvement was required in the areas of risk management and the implementation and review of same.
- Safeguarding and Safety (Outcome 8) - Improvement was required in staff knowledge on the types of abuse and policies and procedures regarding the prevention, detection and response to abuse.
- Healthcare Needs (Outcome 11) - Improvements were required in terms of healthcare provision and planning. In addition, the training/guidance for staff regarding specific health care provision was not adequate.
- Medication Management (Outcome 12) - Medication management, documentation and practice required improvement.
- Governance and Management (Outcome 14) - The levels of non compliance in this centre did not evidence effective oversight and governance.
- Workforce (Outcome 17) - Improvement was required regarding the numbers and skill mix working in this centre, the provision of centre specific training and
performance development of staff.

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that while there was some good evidence of consultation with residents, further improvement was required regarding resident's rights, privacy and dignity in this centre. Practices operating in this centre were observed to be institutional in nature and design.

Inspectors found a separatist approach operating whereby the environment provided was not homely. For example, there were nine offices located within the centre for various provider managerial and administrative roles and posts. The inspectors found this to be excessive in terms of this centres size and the need for this amount of separate office space within the residents home.

There were separate toilet facilities for residents' and staff with the toilet facilities for staff found to be of a higher standard than those provided for residents. A canteen was operating in this centre and staff were observed to dine in a separate location to the residents as opposed to sitting and dining with resident's.

Inspectors found that some care planning information was displayed on residents' bedroom walls regarding specific physical/intimate support care needs. In addition, care planning information was stored in an office that was not found to be locked at all times and residents were observed in this area. Inspectors had been informed residents were not permitted in this area. Inspectors found a stark difference in the approach and attitude demonstrated in the management of staff files and personal documentation and that of residents. These issues were not found to be promoting resident's privacy needs in terms of their care and support and personal information.
Inspectors observed various building, maintenance and grounds staff walking throughout and outside the centre for the duration of the day. As there were automatic doors into the unit and multiple exits/entrances these individuals were continually walking through the centre without knocking, signing in/out or identifying themselves to residents. This was not observed to be conducive to respecting the resident’s right to privacy. There were 10 CCTV (closed circuit television cameras) operating in the centre. Staff informed the inspector these were in place for security reasons. The inspector was informed it was the provider’s policy to have CCTV in their centres. There were no cameras found in bedrooms or bathrooms and were mainly in communal areas and hallways. There was not adequate signage indicating where CCTV was in operation.

Inspectors observed several boxes of rubber gloves on wall mounted shelves and incontinence pads on clear display in residents bedrooms as opposed to been stored away privately and discretely. Such measures in place were observed to be designed for staff convenience as opposed to for resident’s right to privacy and dignity.

A complaints log was in place and was reviewed. The inspector found multiple residents had made numerous complaints regarding the lack of provision of hot water in this centre and their dissatisfaction with not being able to have a shower in accordance with their daily care plans. The inspector checked the water temperature on the day of inspection and found it was warmer in the female side of the centre. Staff spoken to stated that the water was never very warm in the centre. Members of management present on the day of inspection stated this matter had been addressed by their maintenance department. Only one resident of the fifteen living in the centre had access to an en suite shower and informed the inspector there were no baths in the centre.

Inspectors found some inappropriate/not age appropriate language used by some staff regarding resident activities. For example, residents who attended day services were described as going to 'school'.

**Judgment:**
Non Compliant - Major

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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:
The inspectors found residents had written agreements in place however, improvement was required to ensure fees payable to the services provided were clearly outlined.

The inspectors reviewed eleven written agreements in place which had been signed by the resident and/or their representative. The inspectors found the fees payable were not clearly outlined to indicate the frequency of these charges. Additional charges for which the residents were responsible were not included in the written agreements.

In addition, the inspectors found the written agreement did not comprehensively outline the services to be provided.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The inspector was not satisfied with the levels of social care provision demonstrated in this designated centre based on the evidence reviewed on this inspection.

Residents were spoken to by the inspector and many had lived in the centre for long periods of time. Some residents indicated they were happy with the activities in the centre when asked by the inspector.

Inspector’s observations indicated that many residents in this centre spent the majority of their day in the day room on the day of inspection. Inspectors observed that at all times there were between six and nine residents in this area whereby a television was present and a staff member facilitated one resident to do some colouring.

Some staff highlighted that this was just ‘the day that was in it’, however in reviewing the large whiteboard that was used to schedule activities and residents individual plans and records for residents, it presented that many residents remained in the centre on a
Some residents attended day services run by other services providers on set days. The inspectors were informed that an activities coordinator worked in the centre and saw this person’s office. However this person was not on duty on the day of inspection. Some staff highlighted residents would go on social outings once a week and some other staff stated this occurred once per month.

Inspectors found that three residents had gone bowling and to the cinema in recent times. There was a volunteer on a Monday evening who was utilised to support social activities with a number of residents. One resident who was very independent enjoyed a variety of activities as they had access to their own transport.

Personal plans reviewed were found to require further improvements. For example, in reviewing some residents social care planning with staff there were no goals or objectives achieved in the 2014 or 2015 periods according to personal planning and staff.

Staff stated a new template was in place for this and the inspector reviewed some evidence of goal setting for 2016. One staff outlined positive plans and measures in place to support a resident with self advocacy and attending community groups based on the resident’s choice. However this was not reflected in the resident’s personal plan.

The inspectors found that further improvement was required regarding ensuring personal plans were comprehensively reviewed, updated and based on clear objectives agreed in consultation with residents. For example, some goals did not include specific timeframes, persons who were accountable for completing tasks and supporting residents.

When asked about a residents social care plan, a staff member produced an end of year review from a residents day services. This plan had been completed by another service provider and offered an insight into the resident's participation in their day services over the previous year. The inspector highlighted that while good practice, this did not suffice as a social care plan as it did not include any information on the residential services facilitation of social care needs nor was it completed by the centre. Further staff training was required in this area.

**Judgment:**
Non Compliant - Moderate

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

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

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
While policies and procedures were present there was a disconnect found between risk management policy and documentation and the actual practice within this designated centre.

Inspectors were informed by the clinical nurse manager on duty that all risks were assessed and risk rated and were stored in resident's individual files. Inspectors reviewed a sample of accidents and incidents in the centre that were recorded by staff and signed off as reviewed. Such incidents included marks/bruises found on residents, instances whereby residents refused medication and incidents whereby residents had suffered falls.

The inspectors found that risk assessments in place regarding:
- Residents at risk of falls
- Refusal to take medication
- Residents at risk of choking/aspirating
- Residents at risk of seizure

Inspectors were not satisfied with some staff knowledge in the areas whereby risk had been identified. For example, whereby a resident was assessed as a high risk of choking and had an emergency response plan to manage choking incidents in place. Some staff were not aware of this assessed need and the risk regarding this resident. This resident's emergency choking plan (09/10/15) prescribed the 'Heimlich Manoeuvre' be used in the event of a instance of choking. No staff were provided with any training in this practice nor was there training for any staff in basic first aid, first responder or dysphagia training. Staff were not appropriately trained or knowledgeable as to this risk.

Regarding fire safety, the inspectors found that while procedures, alarms and equipment were in place there was not sufficient evidence that the premises could be evacuated in a safe and timely manner in the event of a fire.

Fire training was provided and the inspector found an alarm, fire fighting equipment, fire alarm and monitoring panel, self closing fire doors and fire marshal system was operating in this centre.

The centres most recent evacuations that took place on 28/04/16 and 24/04/16 indicated it took as long as 35 minutes for staff to evacuate the fifteen residents from the centre. The inspector reviewed the most recent evacuation documentation and found staff had highlighted issues with not knowing how to use the fire walkie talkies, how to read the fire panel, difficulties in trying to evacuate residents through fire doors and difficulties with wheels on beds not moving freely across carpet hallways. The clinical nurse manager stated two residents smoked in their bedrooms within this centre. The demonstration of good evacuation procedures required further review in this centre.

On walking around the centre as part of this inspection the inspector found a 2ft masonry drill bit had been left on the corridor. The inspector gave this tool to the clinical nurse manager highlighting obvious health and safety considerations for residents.
Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
The inspector found there were some measures in place to protect residents being harmed or suffering abuse. There was policy in place and a safeguarding folder was found with a staff information sheet. Staff training in safeguarding was provided and the clinical nurse manager showed training lists to the inspector evidencing staff attendance. However staff knowledge was found to require some improvement in this area.

The clinical nurse manager indicated there were no safeguarding concerns active in the centre at the time of inspection. There were policies and procedures available regarding the adult protection framework and abuse reporting and investigation procedure. The inspector observed a copy of the national safeguarding and protecting vulnerable adults policy and procedures. Copies of the training slides completed were found in the staff information folder also.

In discussing safeguarding with a number of staff, the inspector found some staff could name the different types of abuse and other could not. In addition, some staff were not appropriately familiar with the reporting systems in place regarding the reporting, recording and management of allegations and disclosures. This area requires further review.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.
**Theme:**
Health and Development

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

**Findings:**
The inspectors found residents’ healthcare needs were not met and the action from the previous inspection had not been satisfactorily implemented. There were significant deficits in staff knowledge and healthcare plans and as such the care provided was not timely, appropriate and or in line with best practice. Residents did not have access to the appropriate allied health care professionals or preventative treatments in order to meet their needs.

The inspectors reviewed four personal plans including documentation relating to assessed needs and health care plans. The inspector found a number of healthcare plans had not been developed for prescribed treatments. The inspector spoke to staff in relation to these prescribed treatments however, staff were either not aware of the reason residents were receiving these treatments or had limited knowledge and as such the care and monitoring required for these diagnosed conditions. In addition, staff had no knowledge of the monitoring of symptoms or care required for identified conditions for which residents were at risk.

Health care plans were developed for some assessed health care needs. Staff were knowledgeable on some of the care and support required to meet these assessed healthcare needs. However, the inspectors found that staff knowledge in relation to specific medical conditions was limited and that staff did not have the knowledge or clinical expertise to appropriately care for residents. For example, staff knowledge in epilepsy care, diabetes management, and mental health was not sufficient to ensure it was safe and consistent. In addition, staff spoken to were not fully aware of the details of an emergency plan in place in relation to reinsertion of a percutaneous endoscopic gastronomy (PEG) tube.

Staff informed the inspectors information was not available on healthy eating, which formed part of a diabetes management plan for a resident. Staff knowledge in relation to dietary care for a resident with diabetes was limited. The inspectors found the details in some health care plans did not guide practice as plans had either not been updated to reflect changes following a review or plans were basic and did not adequately outline the care required.

The inspectors found preventative vaccinations had not been provided to residents categorised in at risk groups.

Nursing care was not provided on a consistent basis in order to ensure the assessed healthcare needs of residents were appropriately and safely met.
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):
No actions were required from the previous inspection.

Findings:
The inspectors found residents were not protected by the procedures in place for medication management.

There was an up to date policy in place in the centre on medication management however medication management practices required improvements.

The inspectors reviewed prescription and administration records for resident. Prescriptions contained some of the required documentation however, one medication did not have a dose stated. One PRN medication used for emergency epilepsy management did not have the maximum dosage stated. In addition, a PRN (as required) medication did not detail the indications for use and there was no corresponding guidelines in place as to the circumstances in which this medication would be administered. Staff spoken to were also unclear as to the specific circumstances under which this medication would be administered.

Medication administration sheets did not record the actual time medication was administered and as such did not match the prescription sheet.

Medications were not securely stored. Some medications were locked in a medication cabinet however, the inspectors found two medication presses used for surplus stock to be unlocked and easily accessible on the day of inspection.

There were controlled medications in use in the centre. The inspector reviewed records pertaining to controlled drugs and found all the required documentation as per national guidelines was in place.

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:
The person in charge was not on duty on the date of this inspection. A clinical nurse manager was identified as the person deputising for the person in charge on the day of inspection.

Based on the levels of non compliance evidenced on this inspection across all outcomes inspected, inspectors were not satisfied that the management, monitoring and review systems in place were effective in line with the regulations and standards.

Inspectors were given a number of audits as part of this inspection process. For example, inspectors reviewed a safety and quality assurance audit conducted between 18 and 20 January. This audit highlighted a number of areas whereby works had been completed but also indicated areas that were found not to have been appropriately addressed on this inspection. This was concerning from a governance and management perspective. For example;

- Residents personal plans were identified as requiring further development to ensure specific goals. This audit highlighted 'little evidence that social activities for individuals (especially outside the service) are occurring for individuals'. Inspectors found this remained the same on this inspection despite it being highlighted in this January 2016 audit as going to be addressed within one month.

- Cardiopulmonary resuscitation (CPR), Percutaneous endoscopic gastrostomy (PEG), Epilepsy and Catheter Care training was deemed necessary to support residents based on this January 2016 audit. This was to happen within 3 months. There was no evidence that this had taken place and these areas were all identified as assessed needs and posing potential risks for residents by this provider.

- Healthcare needs were deemed to be appropriately assessed, reviewed and met for residents despite the fact that staff knowledge and in key areas was not adequate. This inspection similarly to the previous inspection found non compliance in this area.
- Fire safety was not highlighted as a concern in the internal auditing in respect of evacuation of the centre. This requires further review based on the evidence reviewed of the last number of fire drills and prolonged evacuation times evidenced.

While the system adopted in the auditing of this (the auditing tool and framework adopted) was found to be beneficial and regulatory based (in design) there was an absence of follow up to ensure that the areas audited as deficient were actually being addressed in practice. This did not therefore demonstrate the appropriate levels of oversight and governance in this centre.

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

**Findings:**
Inspectors were not satisfied with the numbers and skill mix of staff as presented on this inspection and in the evidence reviewed on previous rosters.

While many staff worked in this centre a very long time and clearly knew residents very well, key areas of staff training and development were required to ensure the quality of care of residents was improved.

As evidenced in previous outcomes staff knowledge was a concern in a number of areas. For example, risk, safeguarding, healthcare and social care needs of residents.

There was not a nursing staff on duty at all times in this centre despite the negative findings on this inspection and the previous inspection in the area of healthcare provision.

In reviewing the rosters for the previous three months there were occasions found when staffing levels were below the required levels. The clinical nurse manager highlighted there should always be eight staff on duty however staff stated there is mostly six staff on duty. The actual rosters for the centre showed variance in this regard.
For the duration of the day the inspector observed one staff supervising a day room with anywhere between four and eight residents.

The clinical nurse manager stated recruitment was happening in the area of nursing care and staff informed the inspector that sometimes sick leave was not covered.

**Judgment:**
Non Compliant - Major

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

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<tr>
<td>Date of Inspection:</td>
<td>26 May 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>27 June 2016</td>
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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:
Aspects of service provision in this centre were found to be separatist and institutional in design and practice.

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 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

**Please state the actions you have taken or are planning to take:**
1. All toilet facilities now cleaned twice per day – all are utilized by residents, with the exception of one which is not wheelchair accessible. The cleaning checklist has been reviewed and revised. Toilets are cleaned in the morning and afternoons and signed off on a check list outside each bathroom by cleaners with periodic spot checks on the toilets throughout the day.

2. CNM will go through every bedroom to ensure no care planning information is on bedroom walls and removed if so. Care planning/personal information in respect of residents will be contained in a file in each resident’s bedroom.

3. Continuous communication is taking place at handover and staff meetings to remind all staff that care office door must be kept locked at all times and to remind staff that CNM office has space available for residents to have private consultations/discussions/meetings should they wish.

4. Staff will be reminded at every meeting to uphold resident’s privacy and dignity. This will be a standing agenda item.

5. Three quotes have been obtained to automate access doors so they can remain locked and access to the home can be controlled. Residents will have fob keys for entry.

6. Visitor’s stickers will be sought for all non service staff entering the building will be required to wear them to ensure residents can easily identify who is in their home. These will be located by front entrance door next to visitor’s sign-in book.

7. CCTV signs will be placed by each of the 10 cameras identifying their location and operation.

8. All incontinence pads and disposable gloves will now be stored in cupboards and out of sight in residents’ rooms.

9. Repairs to the hot water system, renewal of worn pipes and boiler has been ongoing since December 2015 and as of June 15th 2016 work is now completed. Maintenance staff member continues to perform weekly temperature / legionella test checks and record.

10. Continuous communication with all staff is taking place regarding use of appropriate language at all times. This item will remain on the agenda at staff meetings.

11. During meal times the full support and attention of staff working is required to minimize choking risk. Staff provide support on a 1:1 basis to some residents, in
particular to those who have dysphagia.

**Proposed Timescale:** 31/07/2016  
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Resident's privacy and dignity was not found to be upheld in this centre in terms of the openness and human traffic observed walking in and out of the centre. In addition resident's personal information and privacy arrangements to protect same were not robust.

**2. Action Required:**  
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. CNM will go through every bedroom to ensure no care planning information is on bedroom walls and removed if so. Care planning information in respect of residents will be contained in a file in resident’s bedroom.

2. Continuous communication is taking place at handover and staff meetings to remind all staff that care office door must be kept locked at all times and to remind staff that CNM office has space available for residents to have private consultations/discussions/meetings should they wish.

3. Staff will be reminded at every meeting to uphold resident’s privacy and dignity. This will be a standing agenda item.

4. Three quotes have been obtained to automate access doors so they can remain locked. Residents will have key fobs for entry.

5. Visitor’s stickers will be sought for all non-contracted people entering the building will be required to wear them to ensure residents can easily identify who is in their home.

6. CCTV signs will be placed by each of the 10 cameras identifying their location and operation.

7. All incontinence pads and disposable gloves will now be stored in cupboards and out of sight in residents’ rooms.

**Proposed Timescale:** 31/07/2016  
**Outcome 04: Admissions and Contract for the Provision of Services**  
**Theme:** Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The written agreements in place for resident did not clearly outline the frequency of fees payable, did not include the additional charges and did not comprehensively outline the services to be provided.

3. 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:
1. Easy read addendums will be added to service agreements outlining any additional charges possibly incurred by residents, services provided, and frequency of payments due.

Proposed Timescale: 31/07/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive social care plan was not in place for some residents whose plans were reviewed.

4. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
1. Service coordinator and Senior Care Worker to meet with all residents to discuss and explore meaningful goals and objectives and that such are documented accordingly in each individuals’ personal plan. Plans will be reviewed monthly and/or as required as situations change to ensure goals include timeframes, staff responsible, and that objectives are realized.

2. A service needs assessment to include social care needs is currently underway. The findings of this will indicate the appropriate numbers and skill mix of staff required on duty to meet the support needs of the residents at all times.

3. Community Employee individual is now in place to conduct daily activities in the day room with residents who are staying home for the day and who choose to take part.
This will be from 9 to 1pm. A second individual is being sought for afternoons.

**Proposed Timescale:** 30/09/2016  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Appropriate social goal planning and objective setting was not in place for some residents and in others did not include the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

**Please state the actions you have taken or are planning to take:**  
1. Service coordinator and Senior Care Worker will meet with all residents to discuss and explore with them meaningful goals and objectives and that such are documented accordingly in each individual’s personal plan. Plans will be reviewed regularly with each resident’s key worker each to ensure goals include timeframes and that objectives are realized.

2. A service needs assessment to include social care needs is currently underway. The findings of this will indicate the appropriate numbers and skill mix of staff required on duty to meet the support needs of the residents at all times.

3. Community Employee individual is now in place to conduct daily activities in the day room with residents who are staying home for the day and who choose to take part. This will be from 9 to 1pm. A second individual is being sought for afternoons.

**Proposed Timescale:** 30/09/2016

**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:**  
Some identified risks were not being managed appropriately in this centre.

6. **Action Required:**  
Under Regulation 26 (2) you are required to: Put systems in place in the designated
centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

1. Risk management training to take place with local management team.

2. After every assessed risk the resulting action plan will be discussed with staff during handovers to inform and ensure their understanding.

3. Basic First Aid training will be provided/updated for all staff. All senior care staff/shift leaders are scheduled to attend a three day training in Occupational First Aid scheduled July/August/September 2016. Care support staff are scheduled to attend a one day basic first aid training on 14th & 21st July 2016. Both trainings cover choking and CPR.

4. 19 staff received Dysphagia and associated risk training in Feb and May 2015. Refresher training in dysphagia will be provided to all staff by the Clinical Partner and Service Nurse, this will be completed by August 10th 2016.

5. All staff has received fire training by an external trainer between March –December 2015 and May 2016. In-service training is underway by a staff fire marshall to demonstrate the use of walkie talkies and how to read the fire panel. An easy to read file is available with photos and instructions on how to read the fire panel and use walkie talkies. Staff to be reminded at meetings to avail of this file. This will occur immediately.

6. An external company has been contacted and requested to carry out a full audit and service of residents’ beds. The maintenance staff do periodic checks and oil wheels.

7. Carpet in hallways have been measured will be replaced with lino to ensure safe and speedy transport of beds.

8. Fire evacuation drills have taken place and the current fire drill paperwork will be amended to capture the actual time of evacuation, in addition to time taken from alarm set off to full return to building.

9. An inspection by the Dublin Fire Brigade, fire prevention section took place on the night of May 30th 2016. These inspections are to occur every six months, thus the next inspection is due in November 2016. No adverse findings were informed following this inspection and a report is available in the service.

10. Communication will be made to all staff to ensure continuous vigilance about health and safety. This will be a standing agenda item on staff handovers and meetings.

Proposed Timescale: 30/09/2016
Theme: Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Documentation reviewed indicated all staff were not familiar with equipment and procedures.

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

Please state the actions you have taken or are planning to take:
1. Fire evacuation drills have taken place since inspection on 15th, 18th and 21st June 2016 and the current fire drill paperwork will be amended to capture the actual time of evacuation, in addition to time taken from alarm set off to full return to building.

2. A bi-monthly safety audit is carried out in the service and results sent to Health and Safety officer. This audit captures the evacuation time following drills during day, evening and night.

3. All staff have received fire training by an external trainer between March-December 2015 and May 2016. In-service training is underway by a staff fire marshall to demonstrate the use of walkie talkies and how to read the fire panel. An easy to read file is available with photos and instructions on how to read the fire panel and use walkie talkies. Staff to be reminded at meetings to avail of this file.

4. Carpets in the hallways have been measured and will be replaced with lino to ensure safe and speedy transport of beds.

5. A regular and on-going schedule of fire drills continue to take place to ensure all staff and residents are involved in this practice and aware of the procedure to be followed in the event of a fire. Three drills take place every 2 months to include am/pm and night drill.

6. An external company has been contacted and requested to carry out a full audit and service of resident’s beds. The maintenance staff do periodic checks and oil wheels.

7. Daily fire checks are carried out by shift leader. An in/out board has been purchased to record residents and staff in the service at any given time. Visitors are reminded to complete the visitor’s book and record times in/out. A notice is placed inside the entrance to inform of this. Also, outside contractors will be reminded by administration staff when they arrive in the service to complete works.

Proposed Timescale: 30/09/2016

Theme: Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The measures in place around the evacuation of the centre did not demonstrate a safe and timely evacuation.

8. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
1. All staff has received two yearly fire training by an external trainer between March – December 2015 and May 2016. In-service training is underway by a staff fire marshall to demonstrate the use of walkie talkies and how to read the fire panel. An easy to read file is available with photos and instructions on how to read the fire panel and use walkie talkies. Staff to be reminded at meetings to avail of this file.

2. Staff fire marshal has begun to conduct random spot checks with individual staff members to measure and ensure their knowledge of procedures and equipment in relation to fire safety. This will be done on an ongoing and regular basis.

Proposed Timescale: 31/07/2016

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:
While staff training had been provided there was a noted gap between training and staff knowledge demonstrated.

9. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
1. All staff receive, two yearly training in safeguarding vulnerable adults. The Service Coordinator has received trainer training in safeguarding vulnerable adults and starting immediately will hold discussion sessions with groups of staff/individuals to measure and ensure understanding of abuse and its types and to include the reporting structure/requirements and procedures around allegations.

Proposed Timescale: 31/07/2016

Outcome 11. Healthcare Needs

Theme: Health and Development
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate and timely care was not provided to meet the healthcare needs of residents.

There were significant deficits in staff's clinical knowledge.

Some healthcare plans were not developed in order to guide safe practice.

Healthcare plans were not consistently updated to reflect recommendations made by allied health care professionals. Some healthcare plans were basic and did not adequately guide safe practice.

Preventative vaccinations had not been provided to residents categorised in at risk groups.

10. 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. All health personal plans are currently being reviewed and updated to reflect recommendations/ treatments by allied health care professionals and to guide safe practice. This is being supervised by CNM. Personal plans will be audited every six months by CNM and Cheshire Ireland Clinical Partner (or when a situation changes). Results will be returned to the Service Manager for analysis and the findings will identify supports and interventions that are required. The learning log will be completed in respect of any findings.

2. Personal plan meetings to occur with small groups of staff to go through and discuss personal plans; and to measure and ensure their knowledge of resident health care needs. Care staff will be reminded of importance of reading and informing themselves of contents of all personal plans. Time is allotted for care staff to read and become familiar with the contents of each resident’s personal file. This will be recorded on an attendance sheet and signed by individual.

3. Training is being sourced externally to address and update staff's clinical knowledge in the area of diabetes and mental health care.

4. Training to be provided in the area of behavioural support management. This will be rolled out in the service for all staff.

5. One behavioural support plan concerning mental health issues will be reviewed and updated by the community mental health team.

6. Flu vaccines are offered annually to all residents. Those who chose to received the flu vaccination last October /November 2015. A discussion has taken place with the GP
and the risk status is monitored of any resident who may require the pneumonia vaccination.

7. Every effort is being made to recruit an additional registered nurse through agencies and job recruitment sites.

**Proposed Timescale:** 31/10/2016

**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:
One prescribed medication did not have a dose stated.

One PRN (as required) medication did not have a maximum dosage stated.

One PRN (as required) medication did not detail the indications for use and there were no guidelines in place as to the circumstances under which this medication should be administered.

Medication administration records did not accurately record the time medication was administered.

Medications were not securely stored in the centre.

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

Please state the actions you have taken or are planning to take:
1. A full review of all residents’ prescription records has taken place with GP and amended accordingly.

2. Staff will be reminded at daily handovers to ensure medication is securely locked at all times. This will be a standing agenda item at each staff meeting.

3. Staff will be reminded at daily handovers re medication changes. Should staff have queries in relation to changes, staff are to consult with prescribing doctor to ascertain written and recorded indications for use and guidelines as to the circumstances in which the new or changed medication should be administered. This will be a standing agenda item at each staff handover meeting.

4. The new Medication Management Policy and SOP clearly indicate that “When PRN medication is prescribed, the prescribing doctor is requested to outline in writing clear
criteria/ instructions for the administration of this medication including the maximum
dose for each administration and the maximum for a 24 hour period.” Staff are also
required to complete the Administration of PRN Medication Plan for all Service Users
having PRN meds and details must also be recorded by staff on the PRN and
Exceptional Medications Record Sheet. This is be reiterated to staff at each handover
meeting. This will be reviewed by CNM every six months or more frequently if clinically
indicated.

**Proposed Timescale:** 31/07/2016

### 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:**

Systems in place were not effective to support, develop and performance manage all
members of the workforce to exercise their personal and professional responsibility for
the quality and safety of the services that they are delivering.

**12. Action Required:**

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

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

1. Outstanding matters from the internal audit of January 2016 will be reviewed by
   Regional Manager and Service Manager. Actions required will be discussed with relevant
   persons responsible for completion.

2. Regional Manager and Service Manager will follow up disseminated actions required
to ensure completion.

3. System of random checks is being introduced across areas of fire safety, health
   needs, personal plans, adult protection to measure and ensure staff knowledge in these
   areas. Where improvement is required it will be documented and addressed in one to
   one performance meetings.

4. Individual performance of staff members is being monitored and recorded by Service
   Manager, CNM, and Service Coordinator. Any matters reoccurring are /will be addressed
   in one to one performance meetings.

5. A Workplace Development Programme has started in the Cara on 1st June 2016, the
times scale for completion will be 31st July 2016.

6. A half day seminar over two days in July 2016 (4 sessions) will be completed with
   staff by a previous HIQA Inspector to ensure they are aware of and familiarize
themselves with the Judgement Framework and the Standards Document. Date to be confirmed.

7. A Task Force has been set up in the Cara to oversee the completion of the Action Plan. The work of the task force will be reviewed on 31st August 2016

**Proposed Timescale:** 30/09/2016  
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Management systems in place in the designated centre did not ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**13. 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:**  
1. Outstanding matters from the internal audit of January 2016 will be reviewed by Regional Manager and Service Manager. Actions required will be discussed with relevant persons responsible for completion.

2. Regional Manager and Service Manager will follow up disseminated actions required to ensure completion.

3. System of random checks is being introduced across areas of fire safety, health needs, personal plans, adult protection to measure and ensure staff knowledge in these areas.

4. On 16th June, 2016 the audit team members and Head of Operations met to review the current audit tool and process for its effectiveness and efficiency. Any changes to the process will be informed to the service.

**Proposed Timescale:** 30/09/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The numbers and skill mix of staff did not meet resident's needs.
14. **Action Required:**
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
1. A service needs assessment to include social care needs is currently underway. The findings of this will indicate the appropriate numbers and skill mix of staff required on duty to meet the support needs of the residents at all times.

2. Community Employee individual is now in place to conduct daily activities in the day room with residents who are staying home for the day and who choose to take part. This will be from 9 to 1pm. A second individual is being sought for afternoons.

3. Every effort is being made to recruit an additional registered nurse through agencies and job recruitment sites.

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**Proposed Timescale:** 30/09/2016

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Arrangements in place regarding staff training and development were not found to be effective.

15. **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. A training needs analysis has been devised and work is currently underway with the Learning and Development Manager to access internal/external training as noted below.

2. Refresher trainings in Dysphagia and Gastrostomy care will take place; PEG/pump training will take place next week. Dysphagia training will be completed by August 10th 2016 by the Clinical Partner and Service Nurse.

3. Training in Diabetes and Catheter care is currently being sought externally.

4. All staff received epilepsy training between September 2015 and April 2016, including administration of emergency rescue epilepsy medication. Refresher training is conducted every 2 years. Concerns re individual staff competencies will be addressed with them in a supportive manner by service management team.

5. The CNM is to attend training on insertion of supra pubic catheter and gastrostomy tube. Awaiting confirmation dates of next external course.
6. System of random checks is being introduced across areas of fire safety, health needs, personal plans, adult protection to measure and ensure staff knowledge in these areas. Where improvement is required it will be documented and addressed in one to one performance meetings.

7. Individual performance of staff members is being monitored and recorded by Service Manager, CNM, and Service Coordinator. Any matters reoccurring are will be addressed in one to one performance meetings.

**Proposed Timescale:** 30/09/2016