Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003447
Centre county:	Kerry
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Patrick Quinn
Lead inspector:	Margaret O'Regan
Support inspector(s):	Vincent Kearns
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
18 May 2016 08:35	18 May 2016 19:30
19 May 2016 12:30	19 May 2016 19:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was an inspection carried out to monitor compliance with the regulations and standards and to follow up on actions from the previous inspection.

How evidence was gathered

As part of the inspection, the inspector met with eight of the nine residents that were in the centre. In general, residents were satisfied with their accommodation, with the personal assistance service they received through the primary care team and the care provided by staff. However, residents expressed concern that staff were rushed and this had become more obvious over the past number of months. Residents emphasised that staff always answered bells promptly but this was frequently to ensure their (resident's) call wasn't urgent and to reassure the resident that they (staff) would return when they had finished the task they were involved in. Residents also expressed the view that their voice was not always heard. For example five close circuit television cameras (CCTV) were installed in corridors which a number of residents were unhappy about. This matter was discussed at a resident's meeting.

However, many residents had challenges with verbal communication and there was a feeling amongst residents that their views were not fully acknowledged with regards to this matter.

The inspectors also met with staff members, the person in charge and the regional manager for Cheshire Ireland. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Description of the service
The provider must produce a document called the statement of purpose that explains the service they provide. This document described the centre as one with 12 self contained apartments with a communal sitting room, kitchen and laundry. The mission of Cheshire Ireland, as set out in its statement of purpose, is to work with the resident to design supports that help residents to "live the best possible life" and to work with the residents in a manner which "is respectful and honest".

The centre is a single storey purpose built apartment complex in Killarney, Co. Kerry. Each resident has an open plan ground floor, single occupancy bedroom, kitchen and living area. Each apartment has accessible toilet and shower facilities. The service is available to both male and female residents.

Residents were able to get out and about by means of wheelchair accessible transport, use their own motorised wheelchairs to get to the town centre or access the nearby train station for longer journeys.

Overall judgment of our findings
The inspectors found that most of the actions from the previous inspection had been addressed. The inspectors found that the service was striving to comply with its stated mission and in many ways achieved it. However, areas were identified by the inspector where, in order to facilitate "the best possible life", more cognisance needed to be given to understanding the residents needs and meeting those needs.

The supports provided to residents by community services were varied and generally easily accessible. For example, residents accessed community occupational therapy, public health nursing service and dietetics. The community "assisted living service" was utilised by all residents with whom the inspector met. This was an individualised service provided to enable residents to get out and about and engage in social activities with the assistance of a personal assistance. This service was also organised through the community care services in conjunction with the Irish Wheelchair Association. Some of the health care practices were unsafe and needed to be reviewed and more closely supervised

The inspector met with the recently appointed regional manager who discussed plans he had for the ongoing development of the centre. These included initiatives such as a programme to support staff in creating the centre as a "great place to work", revision of medication policies and the development of the activities programme available to residents.

Good practice was identified in most outcomes inspected. However, improvements were identified as being required under Outcome 1, Resident's rights, dignity and consultation; Outcome 7, Health and Safety; Outcome 11 Healthcare; Outcome 12, Medication; Outcome 14, Governance and Outcome 17, Workforce. The reasons for these findings are explained under each outcome in 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):
No actions were required from the previous inspection.

Findings:
There were policies and procedures for the management of complaints. Residents were aware of the complaints process. There was evidence that complaints were documented. Where appropriate, complaints were escalated.

A resident's forum was in place and minutes were maintained of meetings held. However, from discussions with residents and staff the inspector was made aware that the forum did not always capture all residents' views. This was discussed with the person in charge and the regional manager at the end of the inspection and a commitment was given to examine ways in which to enhance the way in which resident views were sought and acted upon.

Residents were encouraged to maintain their own privacy and dignity. For example, residents had private access to their apartments, staff knocked before entering residents apartments and residents were facilitated to hold their own records if that was their preference. Personal care practices were respectful and each resident was provided with private sanitary facilities. Each resident had a personal assistant. It was a service funded and supported from community care services. Residents received between four and eight hours personal assistance per week to engage in social activities of their choice. All residents reported this to be working well for them.

In many regards the centre was managed in a way that maximised residents' capacity to exercise personal autonomy and choice in their daily lives. For example, residents had their own apartment, engaged in activities and pursuits of their own choosing and frequently left the premises independently. However, most residents needed assistance

with getting up and going to bed. Residents were dependent on getting this assistance in order to be independent for the rest of the day. Residents stated there was inadequate planning with regards to morning staffing requirements. They spoke of occasions when they were told the evening before that there would be a delay in getting assistance in the morning. Residents were understanding of the demands on staff time and were happy to work with changes to schedule. However, being given short notice of such matters impacted on some residents' ability to confidently plan events or appointments.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The inspector found that the process of admissions was in line with details in the statement of purpose. Contracts of care set out the service to be provided in the designated centre. Contracts of care were signed by the person in charge and next of kin, where appropriate. The fees for the service were outlined on the contracts of care seen by the inspector. This was required by the regulations.

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):
No actions were required from the previous inspection.

Findings:
Residents were actively involved in an assessment to identify individual needs and choices. Assessments had multidisciplinary input. Care plans were implemented, regularly reviewed and resulted in improved outcomes for residents. For example, one resident who had limited verbal capacity had a communication plan which specified how the resident liked to be dressed, what their gestures meant and where the resident liked people to stand when in their room. Providing this level of detail in the plan demonstrated a great awareness of the things that mattered to this resident.

Residents and their family members (where appropriate) were consulted and involved in the review process. For example, residents signed their own plan of care and one resident retained control of their notes within their apartment.

Residents were provided with a social model of care. They were involved in a varied activities programme which included attendance at local day centres, meeting friends and one resident availed of an accredited training programme. The social aspect of care was augmented by the community based assisted living programme. However, staff and residents identified that activities was an area that required improvements. In particular activities which would engage the community of residents in the centre and engage the neighbourhood. One resident spoke about their disappointment that the Cheshire Centre Motivation Project was no longer operational. This was a holiday camp which the resident had enjoyed for many years.

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

Findings:
The centre was homely and well maintained. The design and layout of the centre was in line with the statement of purpose which was to provide an environment that "supported people to shape their destiny". The premises met the needs of residents.

The single storey design and layout promoted residents' safety, dignity and independence. The premises had suitable heating, lighting and ventilation. The house was free from significant hazards which could cause injury. There was sufficient furnishings, fixtures and fittings. The centre was clean and suitably decorated. The matters identified on the previous inspection as needing attention had been addressed.

There was adequate private and communal accommodation. Each apartment had a kitchen with sufficient cooking facilities and equipment. There was adequate toilets, bathrooms, showers which were adapted to meet the needs of residents.

There was a suitable outside areas for residents. Residents had access to appropriate equipment which promoted their independence and comfort such as motorised wheelchairs, hoists and wheelchair adapted transport. The equipment was fit for purpose. Up to date service records were available for hoists which were owned by Cheshire. However, two hoists in use were provided by the Health Services Executive (HSE) and no service records were available for these. Staff were trained to use equipment and equipment was stored safely and securely.

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:
The centre had policies and procedures relating to health and safety. There was an up-to-date health and safety statement. A health and safety committee was in place and minutes were maintained of meetings held. There were satisfactory procedures in place for the prevention and control of infection. The risk management policy was implemented and covered the identification and management of risks, the measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents. However, some risks had not been assessed. In particular the risk attached to the use of a percutaneous endoscopy tube (PEG tube). This is a tube inserted through the skin into the stomach in which fluids and liquid feeds can be given. Neither had there been a risk assessment of the use of the centre by an outside agency and whether or not such an arrangement was safe.

Suitable fire equipment was provided. There was adequate means of escape and fire exits were unobstructed. There was a prominently displayed procedure for the safe evacuation of residents and staff in the event of fire. The mobility and cognitive

understanding of residents was accounted for in the evacuation procedure. Staff were trained and knew what to do in the event of a fire. The fire alarm was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. There were fire drills at three monthly intervals and fire records are kept which include details of fire drills, fire alarm tests and fire fighting equipment. However, fire drill evacuation times were not recorded.

Emergency lighting was in place. There were also arrangements in place for responding to emergencies. Reasonable measures were in place to prevent accidents. Staff were trained in moving and handling of residents where required.

Judgment:
Non Compliant - Moderate

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:
Residents reported to the inspector that staff treated residents with respect and warmth. There was a policy on, and procedures in place for, the prevention, detection and response to abuse which staff were trained on. Staff knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to. Staff had received training in understanding abuse especially as it pertains to adults with disability.

Well written and easy to follow safeguarding plans were in place for residents. The provider and person in charge monitored the systems in place to protect residents. The person in charge documented, investigated and reported allegations of inappropriate behaviour.

The rights of residents were protected in the use of restrictive procedures. Alternative measures were considered before a restrictive procedure was carried out. The use of restrictive procedures was monitored to prevent its abuse and/or overuse. Residents in the centre felt safe albeit they were unhappy about the instillation of close circuit television. One resident was fearful as to how this taped monitoring would be used.

Judgment:
Compliant

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
It was noted on inspection that a documented complaint fell within the definition of an incident which was required to be notified to HIQA. It had not been notified. Subsequent to the inspection this was addressed by the person in charge.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
Residents had access to general practitioner (GP) services and therapies, such as dental, psychology, dietetics, occupational therapy and speech and language therapy. In most situations residents were enabled to independently visit their GP. There was evidence that residents had availed of allied health care services through the primary care team. Residents attended specialist consultants as their needs determined. Residents had been assessed by the dietician and the inspector observed that care plans had been developed to support residents with special dietary requirements. The speech and language therapist had provided guidelines for safe swallowing for a resident with dysphagia (swallowing difficulties) and the occupational therapist had documented recommendations for suitable chairs and assistive devices.

Residents were independent in many regards and such independence was generally well supported and nurtured by management and staff. Residents did have significant health issues in this non nurse led service. Residents accessed health care support from the primary care team including public health nursing support. A staff member worked part time in the centre as a nurse and Cheshire Ireland had in post, a clinical lead person for the region. However, there was deficits in the provision of healthcare. For example:

- there was inadequate medical information accompanying a resident who was non verbal and who attended for a cardiology appointment
- one resident was given fluids via a percutaneous endoscopy tube (PEG). There was no clear written directive as to the amount of fluid that could be given via this tube
- while many aspects of residents' care were well managed and facilitated, the amount of fluid given via the PEG tube was outside normal limits and there appeared to be a lack of onsite clinical awareness or monitoring of this
- there were no records available to confirm that staff had been given appropriate training in the care and management of the PEG tube
- one resident had a delay in being assessed for a communication aid. The person in charge had intervened and asked that greater priority be given to the resident's need for assessment; however, at the time of inspection the resident was waiting more than 12 months for this review.

The inspector spoke with most residents in the centre throughout the day and they provided an in-depth picture of life in the centre and how their needs were attended to. They felt that more staff were necessary as the needs of the residents had changed over time. For example, residents spoke of delays in getting assistance in the morning and staff spoke of being rushed.

The inspector noted that residents had access to refreshments and snacks with a selection of fresh fruit. Residents, spoken with by the inspector, indicated that their individual likes and dislikes were taken into account when shopping and that they were encouraged to buy fruit and vegetables. Staff told the inspector that they would accompany residents on shopping trips. Some residents were capable of shopping independently using their mobility wheelchairs. Other residents had the support of a personal assistant (PA) to help them with their shopping.

The inspector observed that the ethos of the centre encouraged and enabled residents to make healthy living choices in relation to exercise, weight control and dietary considerations. This was supported by information in the personal plans viewed by the inspector.

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

Findings:
The written policies relating to the ordering, prescribing, storing and administration of medicines to residents were under review and the inspector was provided with a draft copy of these polices.

A monthly audit of medication management was carried out. Issues identified were in the process of being addressed; for example, ensuring discontinued medication was signed accordingly by a doctor.

The processes in place for the handling of medicines were safe and in accordance with current guidelines and legislation.

There were appropriate procedures for the handling and disposal for unused and out of date medicines. Residents were responsible for their own medication following an appropriate assessment. However, one resident who was self medicating, was not satisfied that they were requested to sign an administration record each time they took their medication. The resident felt this was unnecessarily bureaucratic and undermining of their competency in this matter. In this instance there was inadequate consideration given to the resident's wishes and preferences, taking into account the nature of the resident's disability.

Controlled drugs were securely stored and administered by the public health nurse. A log was maintained of the medication count at the beginning and end of each shift.

Judgment:
Non Compliant - Moderate

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

Findings:
Management systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. However, the systems needed to be reviewed in order to ensure there was a sound clinical oversight of the practices within the centre.

Six monthly audits were conducted. In the most recent audit it was highlighted that close circuit television required to be installed as a matter of priority. It was unclear from the documentation seen or from what the inspector was told as to the reason why five internal cameras needed to be installed in addition to five external cameras. There were inadequate notices in place advising persons that CCTV was in operation. The system in place to allay residents concerns and fears around the instillation of the cameras was inadequate. For example, one resident expressed concern that CCTV images could be accessed via mobile phones, another resident felt uncomfortable that a resident in partial undress could be seen on camera.

An annual review was overdue. The inspector was advised a new template for this review was almost complete.

There was a clearly defined management structure which identified the lines of authority and accountability in the centre. Work was ongoing to support the person in charge in her multifaceted role. The recently appointed regional manager spoke of working towards facilitating staff to take on delegated responsibilities.

The person in charge (PIC) demonstrated sufficient knowledge of the legislation and her statutory responsibilities. The PIC was engaged in the governance, operational management and administration of the centre on a regular and consistent basis. Residents could identify the PIC.

Judgment:
Non Compliant - Moderate

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

Theme:
Responsive Workforce

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

Findings:
In many regards the findings with regards to staffing were similar to the previous inspection of December 2014. On this inspection a sample of staff files were reviewed. The completeness of the files had improved since the previous inspection and all three random files examined were complete and well organised. The staff files complied with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013. The inspector viewed the policies on staff recruitment and saw that staff had fulfilled the required vetting procedures and had the required references. There was a robust induction process in the centre and this was confirmed by a recently recruited temporary staff member.

There was a low staff turnover and staff and were well known to residents. This indicated continuity of care. Staff demonstrated commitment and stated they enjoyed the work they did. Residents reported that they found staff caring. However, residents were clear in their assertion that there were times of the days when staffing levels were inadequate and/or poorly planned. Residents reported that staff were "run off their feet" and frequently did not have time to talk with them. When staff accompanied residents to hospital appointments, residents reported it was not unusual for staff to be in a hurry back to the centre. There was rarely time to stop for refreshments.

Following the issuing of the last inspection report the provider undertook to appoint a person to participate in the management of the centre. The inspector met, on this inspection, with the two people in the role. Also following the last report the provider committed to completing a staffing needs analysis. This was completed and the person in charge had made a request to senior management for extra staffing. It was identified that there was a need for four staff in the morning and four in the afternoon. Even allowing for this, staffing levels needed to be reviewed. For example, one resident required up to three staff to assist with moving and handling. One resident gave the example of staff being too rushed to assist the resident in choosing their day clothes and residents explained how their various disabilities meant that each activity took longer than for an able-bodied person. Staff confirmed with the inspector that they felt rushed. Residents and staff reported that assistance and interventions were not always provided in a timely manner. While bells were answered promptly to ensure the call was not an emergency, staff regularly had to advise the resident they would return to assist them once they completed the task they were involved in. Residents felt staff did not have time to sit with them, even at times when they were upset.

Mandatory training was provided for staff and new staff were provided with induction. Staff reported that they appreciated the training and induction provided. They commented on the good quality of the training provided. However, staff were not

adequately trained in the management and care of providing hydration and medication via a percutaneous endoscopy tube (PEG). The absence of training in relation to this was a matter of particular concern as a safety alert was issued by HIQA in April 2016 advising providers, as a matter of urgency, to ensure staff were trained and confident in the administration of PEG feeding. The inspectors were not satisfied that staff were fully aware of the potential risks associated with this type of hydration.

The written staff roster did not include cleaning staff or students. In addition the full name of the staff member was not recorded on the roster.

Judgment:
Non Compliant - Major

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:

Margaret O'Regan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003447
Date of Inspection:	18 May 2016
Date of response:	28 June 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents freedom to exercise choice and control in their daily life was impacted upon by they not knowing in advance the availability of staff to assist them with their morning routine.

[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 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
Roster review in progress with staff and the union to ensure all the needs of the service are covered. In the short term staff will check daily with service users for their choice on times they would like assistance with their morning routine the following day or further dates so that service users can have control in their daily lives and make their own plans.

Proposed Timescale: 30/09/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
From discussions with residents and staff the inspector was made aware that the residents meetings did not always capture all residents' views with regards to the organisation of the centre.

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

Please state the actions you have taken or are planning to take:
Meeting held with service users on June 13th 2016 and the offer of getting an external person to chair these meeting was discussed. Service users to bring forward names of people to chair the meeting or the organisation can advertise for an individual and Garda Clearance will be sought for the external person. The advocate would be invited meet with the service users every 4 to 6 weeks. The advocate or service user's representative would then attend part of the centre's management team meeting to bring issues / concerns or feedback to the centre's management team to follow up on.

Proposed Timescale: 30/09/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Up to date service records were available for hoists which were owned by Cheshire. However, two hoists in use were provided by the Health Services Executive (HSE) and no service records were available for these.

3. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
HSE contacted and advised that hoists needed to be service every six months. Hoists have been serviced since the inspection. Cheshire will need to contact the HSE on a six monthly basis to ensure the hoists are serviced.

Proposed Timescale: 23/05/2016

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 risks had not been assessed. In particular the risk attached to the use of a PEG tube.

Neither had there been a risk assessment of the use of the centre by an outside agency and if such an arrangement was safe.

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

Please state the actions you have taken or are planning to take:
Professional guidance has been sought from Speech and Language Therapist (HSE) and Dietician (HSE) regarding the risk assessment for the use of a PEG tube. Speech & Language Therapist reviewed service user with a PEG on 27/06/2016 and Dietician to review on 01/07/2016. Any changes will be documented in the Personal Plan and all staff will be made aware of the guidelines through handover.

Risk assessment has been completed for the use of the centre by an outside agency by Cheshire's Health & Safety Officer on 22/06/2016 and control measures were identified to ensure the safety of the service users.

Proposed Timescale: 05/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drill evacuation times were not recorded.

5. 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:
Fire Drill to be completed to record the actual time of the fire drill evacuation.
This will be completed by the Service Manager or Senior Care Worker.

Proposed Timescale: 16/06/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of misconduct was documented as a complaint, investigated but was not notified to HIQA.

6. Action Required:
Under Regulation 31 (1) (g) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation of misconduct by the registered provider or by staff.

Please state the actions you have taken or are planning to take:
Notification of misconduct to be forward to HIQA and follow up report sent on the 20/06/2016.

Proposed Timescale: 20/06/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were deficits in the provision of healthcare. For example:

- there was inadequate medical information accompanying a resident who was non verbal and who attended for a cardiology appointment
- one resident was given fluids via a percutaneous endoscopy tube (PEG) and there was no clear written directive as to the amount of fluid that could be given via this tube

- while many aspects of residents' care were well managed and facilitated, the amount of fluid given via the PEG tube was outside normal limits and there appeared to be a lack of onsite clinical awareness or monitoring of this
- there were no records available to confirm that staff had been given appropriate training in the care and management of the PEG tube
- one resident had a delay in being assessed for a communication aid. The person in charge had intervened and asked that greater priority be given to the resident's need for assessment; however, at the time of inspection the resident was waiting more than 12 months for this review.

7. 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:
• Medical transfer and Medical Reconciliation form to be completed for all hospital appointments and transfers as an immediate action going forward. This form was implemented in May 2016 with the Medication Policy.
• Speech and Language and the Dietician professional opinion being sought regarding fluid intake through the PEG tube. Speech & Language Therapist reviewed service user with a PEG on 27/06/2016 and Dietician to review on 01/07/2016. Any changes will be documented in the Personal Plan and all staff will be made aware of the guidelines through handover.
• All staff to take part in refresher training on the Management of a PEG Tube under the organisation's updated training module all staff be trained by the 15th of July 2016.
• Follow up on assessment with CRC for Communication Aid in progress and Organisation will get assessment completed privately if not done. HSE speech & Language Therapist reviewed this again on 27/06/2016 and forwarded an e-mail to the CRC for follow up.

Proposed Timescale: 30/09/2016

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 resident who was self medicating, was not satisfied that they were requested to sign an administration record each time they took their medication. The resident felt this was unnecessarily bureaucratic and undermining of their competency in this area. In this instance there was inadequate consideration given to the resident's wishes and preferences, taking into account the nature of the resident's disability.

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

Please state the actions you have taken or are planning to take:
Cheshire clinical team are trying to bring in a change to current policy in order to give service users more independence in managing their medication even though they are unable to physically take their medication themselves. These changes are being discussed nationally with the unions who represent care staff and these discussions are ongoing. The Regional Manager met with the service user to discuss their concerns 1st of June. The Clinical Partner from the south will meet the service user by July 30th 2016 and bring their concerns and wishes to the National Working Group to review and add to the Cheshire Medication Policy. Once agreed at national level the changes required will be put in place to support the service user as required.

Proposed Timescale: 30/09/2016

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:
Management systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. However, the systems needed to be reviewed in order to ensure there was a sound clinical oversight of the practices within the centre.

9. 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:
Clinical governance within the service is the responsibility of the Care Coordinator (nurse). The Care Coordinator would receive support from the Regional Clinical Partner. Within the service the nurse carries out clinical audits on medication management and medication variances (monthly), MARS sheet audits 4 times per week, PRN medication. The clinical partner carries out bi-annual audits on medication management and medication variances, file management / care planning. Further support is available to the Care Coordinator from the Head of clinical services.

Proposed Timescale: 20/06/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review was overdue. The inspector was advised a new template for this review was almost complete.

10. 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:
Template for annual review being developed at present by the Cheshire Ireland Management Team. The 2016 Annual review will be completed by the 31st of December 2016 on the new template.

Proposed Timescale: 31/12/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents and staff reported that assistance and interventions were not always provided in a timely manner. While bells are answered promptly to ensure the call was not an emergency, the staff regularly had to advise the resident they would return to assist them once they completed the task they were involved in. There were extenuating staffing circumstances which were not adequately considered including the need for up to three staff to attend to one resident.

11. 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:
Moving and Handling of the resident was reassessed and the resident now needs 2 staff members for transfers 24/05/2016.

Roster review in progress with staff and the union to ensure all the needs of the service are covered and staffing will be available at different times of the day when assistance is required.

A Care needs assessment of each service user is to be complete by the 10th of July 2016, this information will inform the roster review.

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:
Cleaning staff were not recorded on the roster nor were students on work placement.

12. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
All staff names on duty in the building to be recorded on the roster.

Proposed Timescale: 23/05/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not been provided with access to appropriate training around the management of a percutaneous endoscopy tube (PEG) tube.

13. 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:
All staff to be given refresher training on the Management of a PEG Tube under the organisation's updated training module. This training will be given by the Care Coordinator within the service. Any changes to the management of the PEG or fluid intake recommended by the dietician on the 01/07/2016 will be documented in the Personal Plan and communicated to staff during handover.

Proposed Timescale: 15/07/2016