

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Donegal Cheshire Apartments
Centre ID:	OSV-0003440
Centre county:	Donegal
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Colin McIlrath
Lead inspector:	Ivan Cormican
Support inspector(s):	Lorraine Egan
Type of inspection	Announced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

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

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
26 September 2016 09:10	26 September 2016 18:15
27 September 2016 09:30	27 September 2016 20:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This inspection was carried out to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The previous inspection of this centre took place on 12 and 13 April 2016. The provider was required to attend a meeting with the Health Information and Quality authority (HIQA) on 14 April 2016, where concerns regarding services, including this service were discussed with the provider. In response to HIQA’s concerns, the provider advised of impending changes to the governance and management structures and reporting procedures across the service that would positively impact on the quality and safety of care provided to residents

and address all outstanding concerns. As part of this inspection, inspectors reviewed the 32 actions the provider had undertaken since the previous inspection. Inspectors found that 13 of these actions had not been addressed in line with the provider's response and remained non-compliant on this monitoring inspection.

How we gathered our evidence:

As part of the inspection, inspectors met with all 12 residents in the designated centre. Inspectors observed that residents' bedrooms were individually decorated with personal photographs of family and friends and music posters. Inspectors met with several staff members, including the area manager and a person in charge of another designated centre within the organisation who had been asked to support this service in the emergency absence of the named person in charge. Inspectors observed interactions between residents and staff and work practices.

Documentation such as personal plans, risk assessments, medication records, healthcare plans and emergency planning within the centre was also reviewed.

Description of the service:

The provider must produce a document called the statement of purpose that explains the service they provide. In the areas inspected, inspectors found that the service was being provided as described in that document. The designated centre comprised a single-storey dwelling that accommodated up to 12 residents who may have cerebral palsy, physical disabilities, multiple sclerosis or an acquired brain injury. Residents may also have secondary disabilities which could include an intellectual disability, mental health difficulties or medical complications such as epilepsy. Each resident had their own self-contained studio apartment which had an ensuite bathroom. The centre also had a laundry room which residents could access if they so wished. The house had an adequate amount of shared bathrooms and toilets which were equipped to cater for the needs of residents. There were also adequate communal rooms available for residents to have visitors such as family and friends. The designated centre was located within walking distance of a large town where public transport such as buses and taxis were available. Some residents provided their own transport which they used to access the local community. The designated centre also provided transport for residents.

Overall judgment of our findings:

Inspectors noted that all residents complimented the staff employed in the centre stating that the staff they were very kind and caring. Inspectors also observed staff interacting warmly with residents throughout the monitoring inspection. However, inspectors found that out of the 18 outcomes inspected, six outcomes (including risk management, safeguarding and safety, general welfare and development, healthcare, governance and management and workforce) required significant improvements and were each deemed as being at a level of major non-compliance. These outcome included areas such as poor infection control, a lack of risk management, ineffective management systems ensuring oversight and accountability, lack of clarity regarding evacuation in the event of a fire, an absence of healthcare plans in addition to a lack of opportunities for residents. The inspectors also found that improvements were required in relation to seven other outcomes including residents' rights and dignity, communication, family relationships and links with the community, social care needs, general welfare and development, medication

management and resources. These failings are further detailed in the body of the report and action plan at the end.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors found that the dignity and rights of residents was promoted within the designated centre. Inspectors also found that some of the actions highlighted following the previous monitoring inspection had also been addressed. A sample of residents' personal plans were reviewed, all of which had an intimate care plan in place. Advocacy was also made available to residents when requested. However, inspectors also found that some actions highlighted in the previous monitoring inspection had not been addressed. Inspectors noted that improvements continued to be required in relation to how residents were consulted with in regards to the care provided and in relation to the management of complaints within the designated centre.

Inspectors observed that the centre had procedures in place in relation to managing complaints. The designated centre had easy-to-read complaints posters displayed at various locations throughout the building. These posters detailed to residents, families and visitors how a complaint could be made and how the complaint would be managed. The poster stated that various staff could receive a complaint. However, inspectors noted that the displayed information failed to clearly identify who were the nominated persons to manage complaints in the designated centre, as detailed in the regulations. The inspector reviewed the centre's policy on managing complaints. Inspectors found that this policy failed to clarify that nominated persons were required to manage complaints, as the policy stated that the service manager would manage all received complaints. The inspectors also noted that it was unclear whether resident had received adequate feedback in relation to a documented complaint.

Inspectors reviewed a sample of residents' personal plans. Inspectors noted that some

residents had taken part in the planning of their care through the multidisciplinary process. Inspectors noted that this was an area requiring improvement following the previous monitoring inspection. However, inspectors noted that not all residents had taken part in this process with the multi-disciplinary team.

Inspectors found that residents' meetings were regularly taking place. Inspectors reviewed the minutes of these meetings and found that topics such as complaints and the associated appeals process, health and safety, HIQA and staff recruitment were discussed. Inspectors also noted that an advocate from the national advocacy service had attended a recent residents' meeting.

Inspectors found that staff interacted warmly with residents throughout the inspection process. Residents who met with inspectors also stated that they were treated well by staff currently employed within the centre.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found that there was a policy on communication with residents and staff were observed communicating respectfully with residents in line with their assessed needs. Improvement was required to ensure residents received all required support to communicate to the best of their abilities.

Staff were aware of the different communication needs of residents and inspectors observed staff communicating with residents in a respectful manner. Staff members who worked closely with residents were familiar with residents' gestures, facial expressions and other cues. A staff member explained these to an inspector and facilitated a conversation between a resident and an inspector. The inspector found the resident's communication support needs were consistent with information contained in their communication profile.

Inspectors read some residents' communication plans. Some plans provided limited information to guide staff in communicating with residents. For example, a plan stated 'I will continue to speak to family, friends and staff in my usual way' and 'staff to look for non-verbal cues'. There was no detail of the non-verbal cues used by the resident.

Furthermore, some plans did not contain adequate detail or any detail of residents' communication needs as outlined by staff. For example, a resident's communication support needs could result in behaviours that challenge and this was not identified in their communication plan. Inspectors therefore found the assessment of residents' communication needs was not adequately comprehensive to ensure each resident was assisted and supported at all times to communicate in accordance with their needs and wishes.

It was not evident that residents had received all required support to communicate to the best of their abilities. Residents' communication needs had not been reviewed to determine if assistive technology and aids and appliances could promote their full capabilities.

Information in the centre was available in an accessible format.

Each resident had access to radio, television and the internet.

Judgment:

Non Compliant - Moderate

Outcome 03: Family and personal relationships and links with the community

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

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

On the days of inspection, inspectors found that residents and respite users were supported to develop and maintain relationships with family and friends when staying in the centre. Improvement was required to the support provided for residents to develop and maintain personal relationships and links with the wider community.

Families were invited to attend and participate in multidisciplinary meetings. There was evidence that families were kept informed and updated of relevant issues where the resident or respite user wished for their family to be involved.

Residents could meet with visitors in their private apartments, one of two conservatories or in the residents' communal sitting room.

Some residents spent time with family and friends external to the centre. These visits and outings were facilitated by residents' family members and friends where residents required support.

A number of questionnaires completed by residents and their family members stated families and residents were satisfied with the way in which they were kept up to date with changes to residents' care and support needs.

There was no assessment of residents' wishes to develop or maintain links with the community. Inspectors found a resident who had identified a desire to make a link with the community had not been facilitated to do so, and some residents had support to access the community only once per week. A family member outlined their concern that a reduction in staffing for their family member had resulted in 'a big decline' in the resident's 'cognitive function' which they felt was attributed to the resident's needs not being met.

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):

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

Findings:

On the days of inspection, inspectors noted that there were policies and procedures in place for admitting residents, including transfers, discharges and the temporary absence of residents.

Inspectors reviewed the procedure for admitting residents and respite users to the centre. There was a clear process in place which included a pre-admission assessment. The centre did not admit people on an emergency basis.

Residents had new written agreements in place since the previous inspection. Inspectors viewed a sample of these and found that the service provided and fees charged were clearly stated. However, of the sample viewed one resident's service agreement stated there was no fee charged but an inspector found the resident was charged for utility bills. In addition, one service agreement was not signed by the provider or a person on their behalf, and it was therefore not evident the terms on which the resident shall reside in the designated centre had been agreed.

Judgment:

Substantially 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):

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

Findings:

On the days of inspection, inspectors found that the assessment of residents' social care needs had been reviewed since the previous inspection. However, further improvement was required to ensure a comprehensive review of each resident's social care needs was carried out and that supports were in place to support residents to achieve the best possible life in line with their assessed needs and wishes. A sample of manual handling care plans had also been reviewed since the previous monitoring inspection. However, healthcare plans again failed to meet the assessed needs of residents. This will be discussed further under Outcome 11.

Inspectors spoke with residents, staff, the staff nurse and the provider nominee. It was acknowledged by all people working in the centre at frontline and management levels that the assessment of, and support for, residents to identify their social care needs was limited. Inspectors reviewed a sample of social care plans in residents' folders and found goals had been identified by residents. However, there was no specific timeline for the achievement of goals with many stating 'ongoing'. These included goals relating to a holiday and a resident's aspiration to move back to the area they were originally from.

Furthermore, it was not evident who was responsible for supporting residents to achieve goals or how the achievement or effectiveness of goals would be assessed to ensure they were meeting residents' needs and wishes. There was no outline of how goals would support residents to achieve the best possible standard of living in line with their individual aspirations. The incoming provider nominee said that the centre was not resourced to provide support for residents to achieve goals which were external to the centre, and that while some residents had external personal assistants to support them to achieve goals other residents did not have access, or had limited access, to personal assistants to support them. This area for improvement will be further referred under Outcome 16.

Inspectors found that the assessment of residents' needs did not take account of changes in residents' needs or circumstances. For example, there was no assessment of needs for a resident who had experienced a significant life event in recent months and as a result professional supports were not offered to the resident.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

On the days of inspection, inspectors found that the premises met the assessed needs of residents. The actions from the previous inspection were addressed with the designated centre now suitably decorated. Items had also been removed from conservatories to allow residents the full use of these rooms. However, inspectors found that improvements were required in relation to the maintenance of residents' wheelchairs.

The designated centre comprises 12 self-contained apartments. Inspectors found that each apartment promoted the independence of residents and was readily accessible. Residents' apartments had an en-suite bathroom, small kitchenette and suitable amounts of storage available. Inspectors found that the centre was warm, clean and suitably decorated throughout. The centre also had a suitable amount of reception rooms which residents could use to meet family and friends. Inspectors found that each apartment had individual access which promoted the independence of residents.

Inspectors reviewed the maintenance records for equipment within the designated centre and for the most part found that equipment was serviced. However, inspectors found that the maintenance of one resident's wheelchair had not been carried out as scheduled.

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:

On the days of inspection, inspectors found that the health and safety of residents and visitors was promoted within the designated centre. The actions from the previous monitoring inspection had been addressed with revised risk management procedures now in place for the use of an activity room by external parties. However, inspectors found that significant improvements were required in relation to risk management, fire precautions and infection control.

Inspectors reviewed the risk management procedures within the designated centre. The provider had documented risks in relation to residents and the centre. The person in charge highlighted risks for residents such as the use of bed rails, falls, dysphagia, personal cookers and transport. Inspectors noted that all identified risks had been risk rated with appropriate control measures documented. However, inspectors noted that documentation was also present which indicated that one resident may be at substantial risk within the centre. Inspectors found that the provider had no risk management plan in relation to this risk and as such had limited control measures in place to negate this risk. This was brought to the attention of the provider on the day of inspection and will not be discussed further in this report to protect the identity of the resident. Inspectors also noted that a risk assessment had not been carried out to support residents with conditions such as epilepsy to access the community.

Inspectors also noted that a prescription sheet which had two sources of paracetamol charted as required failed to sufficiently highlight to staff the paracetamol content of both medications. As such, the maximum combination of these medications which could be safely administered to the resident in any 24-hour period was not clear.

Inspectors reviewed identified risks for the designated centre. Inspectors found that highlighted health and safety risks such as fire, vehicles, maintenance and lone working had no risk rating in place. Inspectors also noted that a risk assessment form with documented risks such as evacuation procedures, sun exposure, slips and choking had no indication as to who the risk was in relation to and also had no risk rating or control measures listed. Inspectors noted that risk management plans in relation to fire, electrical, emergency procedures and access and egress were all rated as high risks even though effective control measures were in place to negate these risks.

Inspectors reviewed fire precautions within the designated centre. Inspectors found that fire equipment such as extinguishers, emergency lighting, alarm and smoke detectors were regularly serviced. The provider was also carrying out regular checks of the above

mentioned fire equipment, door releases and emergency exits. The provider was also carrying out regular fire drills. Inspectors observed that evacuation procedures were also prominently displayed within the centre. Inspectors reviewed these procedures which indicated that an evacuation may be either full or partial. Inspectors met with staff and the fire representative for the designated centre in relation to these partial or full evacuations to ascertain when an emergency may require a partial evacuation. Neither staff or the fire representative could detail as to when a emergency would require a partial evacuation. The fire representative also stated that fire drills had not been carried out in relation to partial evacuations.

The inspector reviewed the personal emergency evacuation plans (PEEPs) for residents and respite users. Inspectors found that full-time residents had an individual PEEP in place to guide staff in relation to evacuating them in the event of a fire. However, the inspector found that respite users had no individual PEEP in place.

Upon entering the designated centre, inspectors asked staff if any resident was currently listed as having Methicillin-Resistant Staphylococcus aureus (MRSA). Inspectors were reassured that MRSA was absent from the designated centre. However, inspectors reviewed documentation which indicated that a resident may have had MRSA on the day of inspection. Inspectors noted that alcohol gel was readily available in relation to hand hygiene but the centre had no other infection control precautions implemented to reduce the risk of transfer of MRSA to residents, staff or visitors. This was brought to the attention of management within the centre on the evening of inspection.

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):

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

Findings:

There was a policy on the protection, prevention, detection and response to allegations of abuse. Staff spoken with were knowledgeable of the types of abuse and outlined what they would do if they received an allegation of abuse. Improvements were required to ensure there were appropriate measures in place to safeguard residents

from the risk of financial abuse.

The provider was aware of the regulations in regards to investigating allegations of abuse and had notified HIQA accordingly. Residents spoken with said they felt safe in the centre. A retrospective allegation of abuse was made to an inspector on the day of inspection and the inspector relayed this information to the provider nominee who met with the resident and formally notified HIQA of the allegation. The provider nominee outlined the measures which were taken to safeguard the resident.

Inspectors found a practice relating to the use of residents' finances did not provide adequate protection to safeguard residents from the risk of financial abuse. This had been identified in the weeks prior to the inspection by a person employed by the provider. However, staff working in the centre had not been provided with information to ensure this practice did not resume and therefore ensure residents' finances were safeguarded. Inspectors asked the provider to respond immediately to ensure the risk to residents was mitigated. The provider outlined immediate measures and informed inspectors this practice had ceased.

The use of restrictive practices was monitored and there were systems in place to ensure any restrictions in use were the least restrictive. Inspectors found residents had consented to the use of any aids which could be identified as restrictive. Chemical restraints (medicines which are not required to treat a medical condition and are used to modify a person's behaviour) were not prescribed for any resident living in the centre.

Some residents required support with behaviour that challenges. Inspectors reviewed residents' behaviour support plans, met with residents and spoke with staff working in the centre. While some staff spoken with could clearly outline the support a resident required, the resident's behaviour support plan did not reflect this information. In addition, the plan provided inadequate guidance for staff to support the resident when accessing services or recreational activities external to the centre. The plans viewed contained limited information to guide staff when supporting residents with their behaviour and therefore did not provide staff with up-to-date knowledge to support residents to manage their behaviour.

Judgment:

Non Compliant - Major

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:

On the days of inspection, inspectors found that the person in charge was knowledgeable in relation to the events which are required to be submitted to HIQA. Inspectors also noted that the person in charge also maintained a log of all notifications which had been submitted to HIQA.

Judgment:

Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

On the days of inspection, inspectors found that improvement was required to the provision of education, training and employment opportunities for residents. There was no formal assessment of residents' wishes in regard to accessing opportunities for education, training and employment. Inspectors were informed that these assessments were included in residents' social care plans; however, a review of these showed that this was inaccurate as not all plans identified residents' wishes in this area.

Some residents accessed an on-site day service, however this was not provided for all residents. In addition, it was not evident the residents accessing the day service were being supported to identify alternatives where they so wished. A resident accessing the day service told inspectors they wished to leave the day service and access a class or programme external to the centre. This had been discussed at the previous inspection and there had been no progress in addressing this in the intervening months. Although a staff member spoke of supporting the resident by identifying possible courses, inspectors found the lack of formal mechanisms to support residents to identify their wishes in this area resulted in residents' wishes not being supported.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

On the days of inspection, inspectors found that certain aspects of residents' healthcare needs were being met. However, overall inspectors found that significant improvement was required in this outcome to meet the healthcare needs of each resident.

Inspectors reviewed a sample of residents' files and found that residents' healthcare needs were assessed using a best possible health template. The template assessed residents' needs in areas such as pressure area care, toileting, personal care and skin integrity and support with eating and drinking. Inspectors found in some instances that residents who required attention in relation pressure area care had no further follow up documented.

Inspectors reviewed the health care plans for residents with epilepsy. Inspectors found that the health care plans lacked sufficient detail to support staff in relation to caring for residents with epilepsy. The provider used a standardised epilepsy care template. In some instances, inspectors found that care plans had areas such as triggers of seizures, details of the seizure and recovery time from a seizure left blank.

Inspectors reviewed a sample of residents' files in relation to their healthcare needs. Inspectors noted that these files failed to clearly identify the medical history of residents and failed to appropriately implement healthcare plans in relation to their individual needs.

Inspectors spoke with residents' families who could clearly articulate the medical history of residents; however, these histories were not available on residents' files. Inspectors also found that residents with significant healthcare needs and a history of hospital admissions had no plan of care in place to guide staff in relation to their care.

Inspectors also found that equipment used to support the healthcare needs of residents was in some instances extremely dirty. Inspectors reviewed the manufacture's recommendations for this equipment which stated that components of the equipment should be cleaned daily while others should be cleaned monthly. Inspectors also spoke with staff who were unaware of the cleaning requirements of this equipment.

Inspectors found that residents had access to allied health professionals, such as speech and language therapists, dentists, opticians and chiropodists. Residents also had access to general practitioners (GPs).

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:

On the days of inspection, inspectors found that the centre had procedures in place relating to the ordering, prescribing, storing and administration of medicines. However, inspectors found that improvements were required in relation to the prescribing of medications. The provider had addressed some of the actions from the previous monitoring inspection with all residents now assessed in regards to the self administration of medications. However, inspectors also found that medication audits had not taken place as detailed in the action plan response submitted by the provider following the previous monitoring inspection, the action in regards to this can be found under Outcome 14.

Inspectors reviewed a sample of prescription sheets and administration records of medications within the designated centre. Inspectors found that a resident who required buccal midazolam to support the care of their epilepsy failed to have this medication prescribed. Inspectors found that this medication was labelled and present in the resident's medication storage press.

Inspectors spoke with staff who stated that residents need their medications to be crushed prior to administration. Inspectors reviewed the prescription sheets for these residents and found that the prescription sheet failed to state that the residents' medications should be crushed prior to administration. The inspectors reviewed the provider's policy on the administration of medications which indicated that medications which were to be crushed should be identified on the individual resident's prescription sheet.

Inspectors spoke with a number of staff who had detailed knowledge in regards to the administration of medications. Staff also stated that they would seek medical advice in the event of a medication administration error.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

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

Findings:

On the days of inspection, the designated centre had a statement of purpose in place which set out the aims, ethos and objectives of the organisation. It also stated the facilities and services which were to be provided to residents. The actions from the previous monitoring inspection were addressed with a revised statement of purpose now containing the whole time equivalent for all staff, room dimensions and the complete organisational structure.

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

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

Findings:

On the days of inspection, inspectors found that management systems in place within the designated centre were not sufficiently robust and failed to support and promote the delivery of safe, quality care services. Improvements were required regarding the governance and management of the centre.

The inspectors found that a number of actions from the previous monitoring had not been addressed within the agreed timelines submitted to HIQA, such as the recruitment of a nurse which occurred on the week prior to this inspection. Inspectors noted that

this action was two months outside the agreed timeline which was submitted to HIQA by the provider.

Inspectors also found that a management investigation into the operations of the designated centre which they had previously committed to completing in addition to the recruitment of a senior care worker had also not been completed since the last monitoring inspection. Inspectors also found that planned staff supervision had not taken place as detailed in the action plan response from the previous inspection.

At the time of inspection, inspectors found that appropriate arrangements were not in place for the oversight of the centre. The person in charge was absent and no alternative arrangements had been put in place in terms of delegation of responsibilities and oversight. The area manager, spoken with at the time of inspection, confirmed there were no alternate arrangements in place in the absence of the person in charge. Post inspection, a person in charge was seconded from another designated centre to cover four days a week.

Inspectors reviewed the six monthly audits and the annual review of the quality and safety of care in the designated centre. The six monthly review highlighted areas for improvement such as social interactions, residents' awareness of personal plans and staff training needs. The annual review highlighted required improvements in areas such as complaints, review of social care plans, directory of residents and tenancy agreements. However, inspectors found that the annual review and the six monthly audit failed to recognise areas of concern which have been discussed throughout this report such as safeguarding, risk management, healthcare, needs staff training and social care needs.

Overall the centre continued to be in significant non-compliance with the requirements of the regulations. Inspectors found that the quality and safety of care delivered to residents was not at all times effective and as such posed a significant risk to residents.

The provider had recently met with HIQA. At this meeting the provider proposed changes to the governance and management structures and reporting procedures across the service that would positively impact on the quality and safety of care provided to residents. Inspectors found that there was no evidence of these proposed changes and that the oversight of the designated centre remained a significant area of concern which required improvement.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

On the days of inspection, inspectors found that the provider had notified HIQA of the emergency absence of the person in charge. Inspectors noted that it was unclear if the person in charge would be absent for 28 days or more. Inspectors found that the area manager was knowledgeable in relation to notifying HIQA if it became apparent or evident that the person in charge would be absent from the designated centre for 28 days or more. However, as outlined in Outcome 14, there were no arrangements in place should this occur.

Judgment:

Compliant

Outcome 16: Use of Resources

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

Theme:

Use of Resources

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

On the days of inspection, inspectors found that the designated centre was inadequately resourced to meet the assessed needs of all residents. As discussed under Outcome 5, it was acknowledged by all persons working in the centre that the assessment of, and support for residents to identify their social care needs was limited. Some residents accessed an on-site day service; however, inspectors found that this service was not provided for all residents.

A resident who wished to leave the day service and attend classes external to the designated centre was unable to do so due to lack of staffing resources. The incoming provider nominee also acknowledged that the centre was under resourced to meet the social needs of all residents and was engaging with an external funding body in order to procure more funding for the designated centre.

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:

The provider had not addressed the five actions under this outcome that were required from the previous inspection. The provider had failed to ensure an adequate number of staff were working in the centre, appoint appropriate skill-mix of staff, provide required training for staff and ensure staff were appropriately supervised.

At the previous inspection it was not evident the hours of nursing care and support provided was meeting the needs of residents. This had been brought to the attention of a senior manager at that time. However, this had not been addressed.

The provider had carried out an analysis of the staffing levels and skill-mix required in the centre. A person who was assisting with the inspection, and who held a management role in another centre operated by the provider, reviewed the analysis with inspectors. This person could not ascertain the required staffing levels from the document and said the review did not appear to be accurate.

Staff training:

A training needs analysis for the centre was documented. However, inspectors found that some residents' healthcare and support needs had not been included as part of the analysis. An inspector spoke with the person who had completed the analysis and found this person did not have the necessary knowledge to complete the analysis.

Inspectors viewed the training records and found it difficult to ascertain which staff members required training or updated training. Two differing records were given to inspectors. Inspectors were informed one copy was the organisation's copy which was controlled by one person working in the organisation's head office and the second copy was a record maintained by the centre. Notwithstanding the system for updating the central copy at the end of every month the inspector found the records differed.

From reviewing both records and speaking with the person who was coordinating the training needs analysis and a person participating in management the inspector determined that staff had not received all required training. This included training in safeguarding residents and the prevention, detection and response to abuse; fire

prevention and first aid; manual handling; responding to behaviour that is challenging including de-escalation and intervention techniques; infection prevention and control; first aid; dysphagia; food hygiene; epilepsy; diabetes; and the administration of buccal midazolam.

Due to the inconsistent training records, inaccurate training needs analysis, and failure of the provider to ensure staff had received all required training, it was not evident that the provider had an effective system in place to ensure staff received all required training.

Staff supervision:

The provider had stated in the previous action plan that one-to-one meetings would take place with all staff members on a six weekly basis. These had not commenced and inspectors found that the failure of the provider to implement an appropriate system to ensure all members of staff were appropriately supervised had the potential to impact negatively on the care and support of residents.

Staff files:

An inspector reviewed a sample of staff files and found they did not contain all information required by the regulations. For example, the work the person performed in the centre and a reference from the employee's most recent employer. Some staff files contained references from employee's previous colleagues rather than references from previous employers. It was therefore not evident that the provider had implemented an effective system to ensure that the requirements of Schedule 2 were met.

Some staff working in the centre were employed by external organisations. There was no written agreement with these external organisations to ensure that the information specified in Schedule 2, for example evidence of Garda vetting and appropriate training, was in place for these persons.

A person was working in the centre in a volunteer role as part of a work placement. Evidence of Garda vetting, working hours and identification was maintained. However, this person did not have their roles and responsibilities set out in writing.

Staff rota:

An actual and planned staff rota was maintained in the centre. The rota had been amended since the previous inspection and contained detail of the staff who were working in the centre. However, the staff rota did not clearly identify the working times of all staff, for example 'night' was used to denote waking night staff and the start and finish time was not specified.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

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

Theme:

Use of Information

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

On the days of inspection, inspectors found that the provider had records in place as listed in Schedule 3 and in Schedule 5 of the regulations. However, inspectors also found that improvements were required in relation to Schedule 2 documentation and in relation to staff training records as discussed in Outcome 17.

Overall, inspectors found that documentation within the designated centre did not readily support staff in the delivery of residents' care. Inspectors found that residents had numerous files in place, each of which contained repetitious documentation which failed to clearly identify the care support needs of residents.

Judgment:

Compliant

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:

Ivan Cormican
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003440
Date of Inspection:	26 and 27 September 2016
Date of response:	03 January 2017

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:

The provider failed to ensure that two nominated persons were listed in the designated centre to manage complaints.

1. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

complaints are appropriately responded to and a record of all complaints are maintained.

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

- The Provider has amended the display posters within the centre to name both the nominated person (PIC) and a second person (the PPIM) who is available to take complaints. A Provider staff member (Regional Quality Officer) external to the service has also been listed on the poster as available to take complaints.

Proposed Timescale: completed 28/09/16

Proposed Timescale: 28/09/2016

Theme: Individualised Supports and Care

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

The provider failed to ensure that all residents were informed of the outcome their complaint.

2. Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

- All complaints outcomes have been communicated to residents involved.
- The complaints file includes a summary of outcomes of each complaint. A survey sheet will be completed once each complaint has been resolved denoting if the complainant is happy with the outcome. Where the complainant is unhappy they will be informed of the appeals process.
- The Regional Quality partner will complete a monthly complaints review and send to the PIC and Regional Manager. Any resolved complaint where the outcome has not yet been discussed with the complainant will be notified to both the PIC and the Regional Manager for follow up.

Proposed Timescale: completed 27/09/16

Proposed Timescale: 27/09/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

It was not evident that each resident was assisted and supported at all times to communicate in accordance with the resident's needs and wishes.

3. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

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

- The communication section of all care plans is being reviewed to ensure that sufficient detail on non-verbal cues and other supports required has been included where appropriate.
- One resident who can exhibit aggressive behaviours during communication has had their care plan reviewed and a positive behavioural support plan is being put in place with both the resident's and staff's involvement to ensure they have opportunity to communicate their wishes.
- The communication section of Care plans will be reviewed at least annually by the PIC/designate and more frequently where a change of health or other circumstance requires it to ensure it meets the needs of individual service users.

Proposed Timescale: 31/01/2017

Theme: Individualised Supports and Care

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

Residents were not facilitated to access assistive technology and aids and appliances to promote their full capabilities.

4. Action Required:

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

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

- Assistive technology assessments have been held with one resident on 17th November. As a result the resident has been provided with a call system suitable for their use to ensure they can call staff if they require support.
- A second resident has a SALT assessment planned for 7th December 2016 after which a technology assessment will be held to ensure their communication needs are supported.
- The communication sections of all care plans are being reviewed with residents to ensure they contain sufficient information on the residents support needs and wishes.
- The communication section of care plans will be reviewed at least annually by the PIC/designate and more frequently where a change of health or other circumstance requires it to ensure it meets the needs of individual service users.

Proposed Timescale: 15/02/2017

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

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

Supports for residents to develop and maintain personal relationships and links with the wider community in accordance with their wishes had not been provided.

5. Action Required:

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

- An assessment of wishes in relation to maintaining links with the community and personal relationships is being completed for all residents.
- A recording system detailing social and family contacts has been implemented within resident's files within the centre to evidence levels of community and social access. The Provider and PIC will ensure each resident has opportunity to increase their levels of community access during quarter 1 2017 according to their wishes.
- The PIC/designate will monitor levels of community access monthly and notify the Provider of any concerns.
- One resident has been supported to access a Resource centre of another Provider according to their wishes commencing 15th December.
- 2 x further residents are being supported to have positive behavioural support plans in place to ensure they can be safely supported to increase their access to the community and family at their request
- The Provider is proactively working with funders to secure a significant increase in funding for the provision of social supports to residents. This will enable higher levels of community access to be supported according to their wishes.

Proposed Timescale: 31/03/2017

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:

A resident's agreement for the provision of services did not include the fees to be charged.

6. 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:

- All Resident's agreements for the provision of services now include detail on fees charged. All agreements will be reviewed at least annually or as circumstances change and updated as required.

Proposed Timescale: 27/09/2016

Theme: Effective Services

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

The terms on which a resident shall reside in the designated centre had not been agreed in writing with the resident.

7. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

- All terms for provision of service have been agreed and Service Agreements have been signed by both the resident/representative and the Provider.

Proposed Timescale: 27/09/2016

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:

1. The assessments of residents' needs were not adequately comprehensive.
2. Some needs were not reviewed as required to reflect changes in need and circumstances.

8. Action Required:

Under Regulation 05 (1) (b) 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 as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

- An assessment of wishes in relation to maintaining links with the community and personal relationships is being completed for all residents. Information in the

assessment will clearly document the resident's wishes.

- Each resident will be assigned a key worker of their choice who will be responsible, overseen by the PIC for assisting the resident to progress and review their goals. Progress will be noted on Care Plans .
- A recording system detailing social and family contacts has been implemented within resident's files within the centre to evidence levels of community and social access.
- All residents social care plans are being reviewed with the resident and their representative where appropriate to ensure detailed information is included of their wishes.
- Care plans will be reviewed at least annually by the PIC/designate and more frequently where a change of health or other circumstance requires it.
- The Provider is in discussion with funders to secure a significant increase in funding for the provision of social supports to residents. This will enable higher levels of community access to be supported through the provision of more social support hours.

Proposed Timescale: 31/03/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

It was not evident that personal plan reviews assessed the effectiveness of each plan and took into account changes in circumstances and new developments.

9. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

- Each resident will be assigned a key worker of their choice who will be responsible, overseen by the PIC for assisting the resident to progress their goals. Progress will be documented on Care Plans.
- All care plans will include timescales for actions, person's responsible and will be reviewed on at least an annual basis or more frequently as required by the PIC/designate
- Additional Reviews will be carried out where a significant change in the person's life/health means a change in need. The PIC/designate will be responsible for overseeing the operation of the care plans.
- The effectiveness of care plan reviews will be assessed by the Provider through 6 monthly internal audits and the annual review which will include individual feedback from individual residents.

Proposed Timescale: 31/1/17 and ongoing

Proposed Timescale: 31/01/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The provider failed to ensure that all wheelchairs were appropriately serviced.

10. 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:

- One wheelchair which was overdue has been serviced.
- A schedule of required servicing for assistive equipment is in place in the centre and will be reviewed 6 monthly to ensure all servicing is up to date.

Proposed Timescale: Completed 15/10/16

Proposed Timescale: 15/10/2016

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:

1. The provider failed to ensure that risk management procedures within the designated centre were effectively reviewed and implemented in relation to specific risks to residents.

2. Identified risks did not all have appropriate risk ratings applied.

3. There was a failure to recognise a potential risk in regards to the prescribing of paracetamol.

11. Action Required:

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

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

- A Risk assessment in relation to one resident requiring specific supports has been put in place with guidance protocols for staff.

- Risk Assessments will be conducted independently for all SU and placed in the active file. All SU risk Assessments will be rated according to assessment and findings. All risk assessments will be reviewed at least annually or more frequently as required by the PIC/Designate.
- The Risk Register is being reviewed and will be adapted to ensure it is site specific.
- Partial fire drills will be undertaken for day, night and weekends. This will also include information sessions to staff as to the difference between full and partial evacuation.
- A risk relating to paracetamol use was reviewed and discussed with the residents GP and amendments made to the MARS sheet on 29th September 2016. Clinical medications audits are being carried out monthly in the service Medications are signed in by the Clinical Nurse Manager. The Clinical Nurse Manager oversees the signing in of all medications and that information corresponds to the MARS sheet
- Medication training for staff has been carried out in October 2016, including refresher and full training as required.

Proposed Timescale: 15/01/2017

Theme: Effective Services

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

The provider failed to ensure that appropriate infection control procedures were implemented in relation to MRSA.

12. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

- 2 x residents were screened on 28th September and found not to have MRSA infection.
- Where required, residents being discharged from hospital will be requested to be screened for MRSA before discharge: Control measures will be put in place until tests results are available.
- Where screening has not taken place in hospital, the Clinical Nurse manager will arrange for test to be carry out by the service
- A cleaning protocol for items of equipment used by residents has been in place since 28th September 2016 overseen by the Clinical Nurse Manager and PIC.
- Infection control training will take place for care staff on 15th December 2016.

Proposed Timescale: 15/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

1. The provider failed to ensure that respite users had personal emergency egress plans.
2. Staff had not received guidance in relation to the partial evacuation of the designated centre.

13. 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:

- All respite users now have a PEEPS in place
- A PEEPs plan will be completed as part of any respite user's admission to the centre.
- The PIC/designate will ensure that PEEPS are added to the weekly fire check to ensure all residents/respite residents PEEPS are complete

Proposed Timescale: completed 15/12/16

Proposed Timescale: 15/12/2016

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:

Staff were not provided with up-to-date knowledge, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

14. Action Required:

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

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

- Positive Behaviour support training has been held for care staff and management on 6th October 2016
- The Provider's Regional Quality Officer is assisting the PIC in compiling a positive behavioural plan for 2 residents who have been prioritised as in need, with the involvement of the residents and their representatives. The residents in question have participated fully in this review process and their wishes will be central to the support plan. The plan will be communicated to all staff supporting the resident. The PIC/designate will oversee and monitor Positive behavioural support quarterly or more

frequently as required.

Proposed Timescale: 31/01/2017

Theme: Safe Services

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

The systems in place did not protect residents from the risk of financial abuse.

15. Action Required:

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

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

- Money Management plans have been reviewed with 4 residents prioritised as at most risk. As a result robust recording systems are in place in relation to supporting residents with their finances, significantly lowering the risk of financial abuse. Resident's wishes have been central to the process.
- All money Management plans will be reviewed annually or more frequently as required by the PIC/designate.
- Money Management plans will be reviewed as part of the Provider's 6 monthly audits.

Proposed Timescale: Completed 14/10/16

Proposed Timescale: 14/10/2016

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents were not supported to access opportunities for education, training and employment.

16. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

- Each resident is having an assessment of their wishes in relation to accessing education, training and employment opportunities completed.
- Each resident will be assigned a key worker of their choice who will be responsible, overseen by the PIC for assisting the resident to progress their

Goals. Progress will be noted on Care Plans.

- The Provider in conjunction with the funder has developed a proposal to provide significant additional social supports to residents. Once implemented additional support hours will be available to assist residents to access opportunities for education, training and employment

Proposed Timescale: 31/03/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

The provider failed to ensure that documentation and work practices supported the best possible health of residents in relation to

Epilepsy care plans

Medical histories and associated healthcare planning

The cleaning of healthcare equipment.

17. 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:

- Protocols to assist staff in the supporting of residents with specific support needs such as epilepsy have been put in place on 29/09/16 giving detail on support required.
- Medical histories are included in care plans for all residents since 30/09/16
- All medical equipment needing cleaned has been identified and a protocol and documentation put in place to oversee its regular cleaning since 29/09/16. This will be overseen by the PIC/designate.
- Significant re-organisation and streamlining of care plan documentation is being completed to ensure best possible health and high quality work practices are supported. All Care plans are being reviewed during this process. By the PIC/designate

Proposed Timescale: 15/02/2017

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:

The provider failed to ensure that residents' prescription sheets contained all medications which were required to support residents' health care needs and that medications which were to be crushed were clearly documented.

18. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

- Prescription sheets were reviewed by the CNM for all residents and now contain all medications required to support the resident's health.
- Any medication requiring to be crushed now has this detailed on the prescription.
- Clinical medications audit are being carried out monthly in the service y the Clinical Nurse Manager.
- Medication training for staff has been carried out in October 2016
- The Clinical Nurse Manager oversees the signing in of all medications and that information corresponds to the MARS sheet
- The Clinical Nurse Manager and PIC will meet on a weekly planning session during which any issues relating to medication management will be discussed and actions taken as required.

Proposed Timescale: Completed 31st October and ongoing audits

Proposed Timescale: 31/10/2016

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:

The provider failed to ensure that the designated centre had clearly defined management structures in place which accounted for situations when the person in charge may be absent from the designated centre.

19. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

- The Provider implemented an interim governance structure on 28th September 2016 in the emergency absence of the permanent Person in Charge including an interim PIC, CNM 1 and Senior Care Worker.
- The Provider has recruited a Service Manager/PIC on a specified purpose contract in the emergency absence of the PIC. The Interim PIC will commence on 10th January 2017
- A revised management structure will be agreed with the funder and implemented to

ensure local governance in the centre consisting of a PIC and 3 PPIMS (CNM1 and 2 senior care workers working 5/7 days).

- The local management team will meet weekly to plan agree actions for that week.
- A fortnightly monitoring report will be forwarded to the RM as part of governance arrangements.
- The Provider will meet formally with the PIC monthly for supervision and support
- The Provider will meet with the Chief Operations Officer monthly for support and planning.

Proposed Timescale: 28/02/2017

Theme: Leadership, Governance and Management

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

The provider failed to ensure that effective robust management systems were in place to highlight and address areas for improvement within the designated centre.

20. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

- A robust Annual Review process will take place in January 2017 (reviewing 2016) designed to highlight areas of improvement required and will include representations from residents and family representatives. Results from the Annual Review will be used to formulate required actions for improvement in 2017
- The Regional Manager will hold a documented meeting with the PIC on a monthly basis tracking progress on required actions and detailing any improvements required.
- A Service Manager/PIC and Clinical Nurse Manager/PPIM are in place and further robust governance and management systems will be implemented through the introduction of 2 Senior Care Workers who will also be PPIMs working 5 over 7 days to ensure governance.
- The Provider will oversee the management of complaints, money management , clinical supports and Safety and quality within the centre through monthly site visits by the Clinical Partner, Quality Partner and Regional Manager who all work external to the centre.
- The Provider has scheduled and will continue to carry out 6 monthly audits which will be themed to ensure that actions identified during previous audits and inspections have been carried out.
- The Regional Manager will advise the Chief operations officer of any concerns that arise in the operation of the centre.

Proposed Timescale: 28/02/2017

Outcome 16: Use of Resources

Theme: Use of Resources

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

The provider failed to ensure that the designated centre was adequately resourced to meet the assessed needs of all residents.

21. Action Required:

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

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

- The Provider is proactively working with funders to secure a significant increase in funding for the provision of social supports to residents. This will enable higher levels of community access to be supported according to their wishes once implemented. An unbundling process of current funding has commenced.
- The Provider Nominee will oversee this process with the Chief Operations Officer.
- The Regional Manager and PIC will ensure each resident has opportunity to increase their levels of community access during quarter 1 2017 according to their wishes.
- The PIC/designate will monitor levels of community access monthly and notify the Provider of any concerns.

Proposed Timescale: 31/03/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The actual staff rota did not clearly show staff on duty during the night.

22. 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:

- The rota has been amended to show the required information

Proposed Timescale: completed 30/09/16

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:

The information and documents as specified in Schedule 2 had not been obtained for all staff.

There was no system to ensure that persons employed by an external organization had all information specified in Schedule 2 of the regulations.

The provider had not implemented an effective system to ensure that the requirements of Schedule 2 were met.

23. Action Required:

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

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

- The documents required for schedule 2 of the regulations have been requested from any staff who had items missing. The PIC will ensure this information is obtained and report any concerns to the regional Manager and Senior HR Partner.
- All staff employed by external organisations has provided the documentation required under schedule 2 of the regulations.
- The Provider has implemented a review of staff files by an HR partner during each 6 monthly audit This will ensure that staff files contain the correct information and where items are required they will be obtained by local management. The HR partner will notify the PIC and Regional Manager of any concerns and follow up action will be taken.

Proposed Timescale: 15/01/2017

Theme: Responsive Workforce

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

It was not evident that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents.

24. 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:

The provider will ensure that a Care needs analysis previously conducted is documented clearly to show the assessed needs of residents

The Provider in conjunction with the funder has developed a proposal to provide significant additional social supports to residents. Once implemented additional support hours will be available to assist residents to access opportunities for education, training

and employment, according to their wishes.

A Service Manager/PIC and Clinical Nurse Manager/PPIM are in place and further robust governance and management systems will be implemented through the introduction of 2 Senior Care Workers who will also be PPIM's and work 5 days over 7.

Proposed Timescale: 31/03/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The lack of formal supervision for all staff including personal assistants and effective performance management systems had the potential to impact negatively on the care and support provided to residents.

25. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

- A schedule of supervision and support meetings has been implemented between the PIC/designate and care and ancillary staff. These meetings have commenced and will be held quarterly.
- The PIC will hold documented supervision and support meetings with PPIM's on a 6 weekly basis.
- The Clinical Nurse Manager will be supported and supervised by the PIC through a documented support meeting, 6 weekly. There will also be 6 weekly site visits and meetings by the Regional Clinical Partner with regard to clinical oversight.
- Group support and guidance will be provided to staff through monthly staff meetings.
- The Regional Manager will hold documented supervision and support meetings with the PIC on a 6 weekly basis or more frequently as required.
- Weekly planning sessions will be held between the PIC and PPIM's

Proposed Timescale: Completed 6th December and ongoing

Proposed Timescale: 06/12/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff did not have access to all required training and the assessment of training needs for staff working in the centre did not identify all required training.

26. 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:

- Training has been held for staff in the following topics:
- A) Positive Behavioural Supports 6/10/16 B) Meds Mgt x 4 full and refresher training sessions completed 13/21/26/27 Oct C) Buccal Midazolam x 2 18/10/16 and 9/11/16 D) Food Safety : 19/10/16 E) Moving and Handling 1/12/16 f) Catheter flush training 28/10/16 and 9/11/16 g) Diabetes Management 9/11/16 h) Dysphagia 7/12/16
- Further Training is scheduled in 2016 as follows: a) Moving and Handling 15/12/16 b) Infection control 15/12/16
- A care needs analysis for the centre will detail the training and staff to be trained for 2017

Proposed Timescale: 21/01/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The roles and responsibilities of a volunteer working in the designated centre had not been set out in writing.

27. Action Required:

Under Regulation 30 (a) you are required to: Set out the roles and responsibilities of volunteers working in the designated centre in writing.

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

- A document containing roles and responsibilities has been provided to placement workers/volunteers within the centre.

Proposed Timescale: Completed 10/11/16

Proposed Timescale: 10/11/2016