

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Cara Cheshire Home
<b>Centre ID:</b>	OSV-0003441
<b>Centre county:</b>	Dublin 20
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	The Cheshire Foundation in Ireland
<b>Provider Nominee:</b>	Violet Lennon
<b>Lead inspector:</b>	Conor Brady
<b>Support inspector(s):</b>	Anna Doyle; Emma Cooke
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	14
<b>Number of vacancies on the date of inspection:</b>	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 unannounced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 01 April 2017 07:30 To: 01 April 2017 16:00

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 05: Social Care Needs
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 was the seventh inspection of this designated centre since the commencement of the regulatory process in disability services in November 2013. The previous inspections of this centre highlighted major non compliance in a number of core outcomes inspected. Following the previous inspection of this centre HIQA issued a notice of proposal to refuse and cancel the registration of this designated centre based on the levels of non compliance found in this centre.

This was an unannounced inspection carried out to specifically inspect the centre against a representation submitted to HIQA by the provider on 16 March 2017. This inspection was conducted to measure this centres compliance with the requirements of the regulations and standards and inform a decision regarding the notice of

proposal to refuse and cancel the registration of this designated centre which was issued by HIQA on 17 February 2017.

How we gathered our evidence:

As part of this inspection, the inspectors met, spoke with and observed a number of residents who resided in this centre. Some residents spoke to inspectors and some residents communicated on their own terms. Fourteen residents were present in the centre at the time of inspection.

The inspectors spoke with the provider nominee, the new person in charge, new staff nurse, senior care workers and care workers. Inspectors arrived early on this inspection and met members of the night staff and observed the morning handover.

The inspectors reviewed documentation such as risk assessments, safeguarding referrals, safeguarding follow up, incidents and accidents, support plans, personal plans, care plans, resident healthcare plans, resident medication records and supporting documentation, finances, management auditing, meeting minutes and organisational policies and procedures.

Inspectors met the provider nominee who outlined existing and planned provider actions regarding changes occurring in this centre since the previous inspection. The HSE (Health Service Executive) as the funding body had also been involved in this process and final planning regarding resourcing was pending according to the provider nominee. The inspector requested this be submitted to HIQA following this inspection. One resident had transitioned out of this centre to a nursing home since the previous inspection and the provider highlighted they could no longer meet this residents needs.

Description of the service:

The provider had a statement of purpose in place that outlined the service that they provided. This needed to be updated to outline the changes that had occurred in the centre since the previous inspection in November 2016 and the inspector requested this document be updated and submitted to HIQA following this inspection.

According to the centres statement of purpose, support was provided 24 hours per day 7 days per week. Residents' had various support requirements including: Cerebral Palsy; Multiple Sclerosis; Hydrocephalus; Acquired Brain Injury; Cerebrovascular Accident (CVA) and intellectual disability.

This designated centre was located in a single story building located in a large park in an urban city location. The centre provided care and support to both male and female residents.

Overall judgment of our findings:

Overall, the inspectors found that this centre remained in substantive non compliance with a number of requirements of the regulations and standards.

Some actions taken since the previous inspection indicated various changes and planned improvements in the operation and provision of services within this

designated centre.

There were examples of some improved outcomes for residents evident but there was also a lot of changes and plans at preliminary stages and 'in process' as opposed to being fully implemented. Many components of the providers representation pertaining to governance and management, cultural change in care provision and the resourcing of centre were only in the process of commencing or had just commenced. It was therefore not possible for inspectors to fully assess the effectiveness of these plans and all components of the representation in an evidenced based manner.

All findings are discussed in further detail within the inspection report and accompanying action plan.

**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 some actions issued in respect of the centre on the previous inspection had been partially addressed however a number of elements of the representation submitted to HIQA had just commenced as opposed to being implemented.

The centre had made some improvements in the areas of residents' finances and residents' rights and dignity. However, the impact of these changes on residents could not be fully evaluated as improvement plans had not been fully implemented at the time of this inspection or were only at introductory phase. In addition, further improvements were required in the area of resident's complaints to ensure that the complaint of each resident and their family are listened to and acted upon.

Since January 2017, residents meetings were now occurring monthly. Additional plans were in place for residents' meetings to occur on an individual basis of which one had taken place at the time of this inspection. Records demonstrated that residents were being consulted with and participated in decisions about their care and about the organisation of the centre. For example, residents were involved in discussions around their finances, purchasing of safes for residents' monies, staffing arrangements and the complaints procedure.

Social activities and plans were also discussed and communicated with residents during these meetings. Although clear actions had not been generated from the meeting to highlight persons responsible for following up on issues raised, inspectors did find some

evidence which demonstrated that resident's views had been acted upon.

In reviewing residents' finances, inspectors found that the use of a 'pooled' account for resident's leisure money had ceased and the provider no longer had an account whereby resident's monies were kept by the provider. Plans were in place for some residents to have their own bank cards and to be supported to access their own money. In the interim, local records were maintained by administration staff under residents individual accounts.

Inspectors found that further improvement was required to ensure that residents were fully supported to take financial responsibilities and have control and access to their own accounts. Staff reported that safes were in place for residents who could manage their own money. However, oversight arrangements had not been clearly established. Staff spoken with were unaware about how the safe system operates and the procedure around supporting residents to use same.

Inspectors found examples whereby staffing arrangements were not sensitive to residents needs and were not upholding their right to dignity and privacy. In reviewing complaint records for 2017, two complaints related to residents and relatives requesting that only females be involved in the provision of intimate care. Residents had also raised this issue during their residents' meetings. In response to this complaint, management committed to reviewing rosters and where possible, have a female staff on duty. However, planned rosters demonstrated that suitable staffing arrangements for the provision of intimate care to females as requested by residents and their relatives was and could not always be facilitated. This did not provide assurance that complaints were being well managed and bring about sustained, positive change in accordance with residents rights and wishes.

While residents were aware of the complaints process and were supported to make complaints, inspectors found evidence where the level of satisfaction had not been recorded for a complaint made by a resident. Additionally records did not demonstrate that all complaints had been investigated promptly.

**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 effective and supportive interventions were provided to residents to ensure their communication needs were met.

Individual communication requirements were assessed in personal plans in all areas such as hearing, speech, vision, reading and writing. Communication care plans accurately reflected the systems in place to enable staff and residents to effectively communicate. Where required, residents were facilitated to access assistive technology to promote their full capabilities.

Inspectors spoke with staff who were aware of the different communication needs of residents and there were appropriate systems in place to meet the diverse needs of residents. Residents were allocated key workers for continuity of care and on-going communications with the residents' families.

Each resident had access to a telephone (both communal and private), radio and wifi. Each resident had a television in their room as well as a communal living area for residents to watch television. Residents were supported and facilitated to access computers and at the request of residents, individual computers had been placed in resident's bedrooms for everyday use.

**Judgment:**

Compliant

**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):**

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

**Findings:**

Similar to previous inspection findings, individual residents have some involvement with the community but were not found to be actively encouraged to participate in community based programmes, initiatives or groups.

On the day of inspection, inspectors noted no activities were planned on the centres whiteboard or diary. However later in the day some residents were observed going out to a local art gallery and residents expressed great satisfaction with this. Additionally, some residents had gone out to the local pub on the previous night.

Inspectors reviewed systems in the centre and found that some residents had

maintained relationships with their families. Five out of the 14 residents attended day centres during the week. However the inspector found that improvements were required to link residents with their surrounding community.

Inspectors found an example whereby a resident's personal goal was to maintain contact with friends and family. The care plan outlined that the resident would like to visit their friend in their house. A review of the resident's visitor book over a two year period indicated that while the friend came to visit the resident, suitable arrangements had not been explored or put in place to facilitate the resident to go visit the friend in their house. From speaking with staff, rationale for this was that the friend comes to visit the resident instead.

Suitable space was available for residents to meet with their visitors in public and in private as required.

**Judgment:**

Non Compliant - Moderate

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

The inspectors found that some progress had been made since the last inspection in resident's personal plans and there was improvements in some residents social care needs. However, further improvements were required in the areas of planned social care, personal goals and objective setting. Inspectors found that plans outlined in the providers representation submitted to HIQA had been commenced but not fully achieved.

From a sample of residents' personal plans reviewed, inspectors found that residents had increased access to activities outside of the centre since the last inspection. However, when residents remained in the centre during the day, activities for residents were found to be very limited. On the morning of the inspection there was no activities

planned for the day. A white board maintained in the staff room indicated that activities for the day were 'tbd' (to be decided). There was no discussion at morning handover regarding residents meaningful day and plans for the day ahead. The focus was primarily on 'allocation' of staff to support residents with personal and intimate care.

Inspectors acknowledged that an activities coordinator had been employed two weeks prior to this inspection and there were some records to demonstrate that this person had commenced meeting with staff and residents to discuss future plans in order to assess and address residents social care plans in line with individual needs, wishes and preferences. However this process was in its early exploratory stage with only a small number of plans reviewed.

While inspectors found that some plans had been recently updated to include some social care goals for residents since the last inspection in November 2016, the plans did not demonstrate who was responsible for the objectives within specified time frames. Also the quality of goal setting required review and some staff highlighted an inability to complete a personal plan and were seeking support and guidance with this task. In addition, while plans were currently been updated in the centre, it was not clear how residents personal plans would be reviewed in order to assess their effectiveness.

Inspectors did not find a clear system whereby short, medium and long term planning was clearly evident to ensure residents were pursuing social activities in line with needs, wishes and preferences.

**Judgment:**

Non Compliant - Moderate

**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:**

Inspectors found that appropriate risk management arrangements were in place in the centre and improvement had been made in the overall management of risk.

Inspectors reviewed staff training records available in the centre and found that most staff had completed training in dysphagia since the last inspection. However, the records available were not complete and the provider agreed to submit the complete records after the inspection. Staff spoken with were knowledgeable about the procedures to follow in this event. This had been an action from the last inspection and was an area of notable improvement.

Regarding fire safety, the inspectors reviewed the fire orders, fire panel, fire fighting equipment and emergency evacuation procedures.

The inspectors found the majority of residents were subject to bed evacuations and personal evacuation plans were updated and in place.

Some residents had transitioned into larger rooms to make bed evacuations easier. Other residents who required the use of supportive equipment had this in place in accordance with their evacuation plan.

Staff were aware of evacuation procedures and explained same to the inspectors both verbally and with a physical demonstration. All exit points were found to be unobstructed at the time of this inspection.

**Judgment:**

Compliant

**Outcome 08: Safeguarding and Safety**

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**

Safe Services

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

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

**Findings:**

The inspectors found that there had been a higher emphasis placed on safeguarding and improvements were noted in terms of demonstrable staff knowledge on the types of abuse, signs of abuse and reporting procedures. However further improvement and attention was required regarding unauthorised visitors accessing the building. This matter was highlighted on the previous inspection.

The inspector found appropriate policy and procedure was in place and the latest guidance from the national safeguarding office was in the designated centre.

A number of safeguarding referrals were in process and the inspector requested outcome reports of all safeguarding investigations pending, be submitted to HIQA on completion. Two reports of alleged neglectful practice to residents were awaiting final

provider reports.

While improved security systems had been implemented since the previous inspection, the inspectors found an incident whereby unauthorised visitors had again gained access to this centre by pulling apart the main electronic doors and entered the centre to 'visit' a resident.

The provider highlighted that Garda were asked to review security arrangements in the centre post this incident. Incidents of unauthorised visitors have featured in the previous inspection report and this further incident does not demonstrate that the residents were appropriately protected and safeguarded by the security arrangements in place.

Regarding therapeutic support provision, the provider has cited some increased clinical input and assessment from HSE services in areas of healthcare and has made appropriate referrals for increased supports where required. The service manager had completed some increased behavioural support guidance for residents as an interim measure until assessment takes place.

**Judgment:**

Non Compliant - Moderate

**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:**

There was a log of all incidents occurring in the designated centre and notification of relevant matters were being made to the Chief Inspector.

The inspectors found evidence of follow up regarding notifications to date. Inspectors found a resident who had been subject to a number of notifications of concern had been transferred out of this designated centre since the previous inspection.

The inspector requested follow up on two notifications pertaining to safeguarding as highlighted in the previous outcome.

**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):**

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

**Findings:**

Overall, inspectors found that resident's opportunities for new experiences, social participation, education, training and employment had not been comprehensively reviewed and addressed since the last inspection.

At the time of this inspection, no resident was actively involved in any education or employment scheme. Inspectors acknowledged that some residents had expressed no interest in education and training opportunities and staff respected these wishes and documented this in residents' personal plans.

Inspectors reviewed a number of personal plans in relation to general welfare and development. Inspectors found that goal setting and objectives tended to be activity based and that there was no meaningful assessment process to establish each resident's educational, employment and training goals.

Staff acknowledged that a complete review of resident's goals was currently underway and that the activities co-ordinator will be responsible for developing and leading on opportunities for residents to avail of education, training, and employment and maintain links with the community.

Inspectors found an example whereby a resident had expressed an interest in going back into employment. The resident had been supported to fill out an application form by staff and a response letter was received in September 2016 highlighting that a job coach was to be assigned to the resident. However, there was no follow up to this letter and staff spoken with and records reviewed did not demonstrate any effort to follow up this for the resident.

Some care plans reviewed identified residents' 'supports for a good life'. A resident had expressed an ambition to move into their own home in the future. On review of the resident's notes and from discussion with staff, it was not clear about how the resident was being supported to achieve this and no arrangements had been put in place to follow up on this.

Similar to previous inspection findings, the centre's policy in relation to supporting people to access training, education and developmental opportunities lacked clear

guidance and direction for staff to support residents in identifying and achieving personal goals in this area.

**Judgment:**

Non Compliant - Major

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

Inspectors acknowledged that some improvements to the healthcare findings on the previous inspection had been implemented in areas such as staff knowledge of resident's healthcare needs and conditions. However, inspectors still found similar findings to the last inspection in the areas relating to residents opportunities to prepare and cook their own meals and record maintenance in relation to PEG (percutaneous endoscopic gastrostomy) management.

Inspectors found staff knowledge in relation to specific healthcare conditions had improved in areas such as epilepsy, dysphagia and PEG management. However, similar to previous findings in relation to PEG management, inspectors found that not all aspects of the policy and guidelines had been implemented. Inspectors noted that documentation created to support the monitoring of the PEG tube and facilitate adequate communication about the PEG tube was not implemented into care plans. This was identified on the last inspection and brought to the provider's attention again.

Improvements were noted from the last inspection whereby residents had access to appropriate dietetic support as required. The provider highlighted that all residents were scheduled to undergo dietician assessment the week following the inspection. Evidenced based guidelines had been put in place to guide staff on feeding plans. Daily records reviewed demonstrated that plans and directions had been implemented into practice. Furthermore, systems were in place to ensure progress was monitored and reviewed three monthly.

Since the last inspection, staff reported that only one resident had been presented with an opportunity to prepare their own meals. While assessments had been created to determine residents ability to be involved in the preparation of food, these assessments had yet to be completed for all residents. Management acknowledged that this was part of a continuous plan and that the assessments were due to be fully implemented.

Resident's spoken with said that they enjoyed the food and that they were supported during meal times. Inspectors observed the lunch time meal and noted that there was appropriate staff in place to meet the assessed needs of the residents.

A full time registered nurse was now in place and provided clinical oversight and supervision of care staff during the week and at weekends. Competency assessments were being carried out by the nurse in areas such as peg management.

Inspectors observed practices whereby the resident's right to refuse medical treatment was respected, accurately documented and brought to the attention of the resident's medical practitioner.

**Judgment:**

Non Compliant - Moderate

**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:**

Overall, inspectors found that residents were protected by the designated centres' policies and procedures for medication management.

The centre had reviewed practices around medication preparation and administering since the last inspection. Systems were in place to ensure that staff administering medication were not being interrupted when preparing resident's medications. For example, staff now wore high visibility vests indicating that a medication round was taking place and staff were to avoid unnecessary interruption. Additionally, the staff member assigned to administer the medications no longer held the phone used by residents to contact a member of staff for assistance. These measures enabled staff to have protected time to concentrate on preparing and administer residents' medications.

There were written operational policies for the ordering, prescribing, storing and administration of medication. Inspectors reviewed a sample of medication prescription records and found these records were maintained in accordance with current national guidelines. Administration records confirmed medication had been administered as indicated to the resident for whom these medications had been prescribed. PRN (as required) medication prescriptions stated the maximum dosage in 24 hours.

Inspectors found an example whereby a medication had been transcribed by a nurse.

On review of the corresponding communication notes with the GP and the transcription section on the medication policy, it was clear that the centre was following local policy and had a system in place to ensure the medicine was signed by the GP within 72hrs as outlined in the policy. Medications that required crushing were prescribed as such by the doctor.

Suitable arrangements were in place for the disposal of medication. Out of date or unused medications were returned to the dispensing pharmacy and records maintained were signed by the receiving pharmacist.

Residents were encouraged and supported to take their own medication where possible. A medication self administration assessment tool had recently been carried out for some residents who expressed interest in taking their own medication.

Medication errors were recorded in an adverse event record book and regularly reviewed. Where issues were identified, action plans were developed and the inspectors found these actions had been implemented. For example, records reviewed demonstrated that refresher medication administration training was provided in response to some medication errors. Additionally, residents refusal to take medications were recorded and brought to the attention of the GP.

**Judgment:**

Compliant

**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):**

No actions were required from the previous inspection.

**Findings:**

The statement of purpose and function required to be updated and submitted to HIQA as it did not accurately outline the management structure changes and numbers of residents. The inspectors requested this be submitted to HIQA following this inspection with these changes.

**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):**

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

**Findings:**

Inspectors were informed of governance and management changes on this inspection when the provider and a new incoming person in charge arrived in the designated centre. While some improvements were noted many areas outlined in the previous inspection were not yet fully addressed by the provider at the time of this inspection.

The inspectors were informed that the new person in charge was transitioned from another designated centre operated by this provider which was in the process of closing. As part of the provider's representation action plan to address regulatory failings identified by HIQA, there were four actions completed and thirteen actions 'in process' regarding governance and management.

Further actions in process included the new person in charge (who at the time of inspection was not fully integrated into the designated centre), the pending recruitment of a new clinical nurse manager, the pending recruitment of an additional nurse and care support hours, changes to internal governance meetings and accountability systems, changes to periodic, six monthly and annual auditing and review.

The provider nominee demonstrated a heightened managerial approach to the key areas of service provision and inspectors did find improvement in the quality of care and service in this centre since the previous inspection. The new person in charge highlighted their intention to improve the fundamentals of service delivery through focussing on core outcomes in addition to staff performance and morale, amongst other things. However as the person in charge was only in post the week prior to the inspection so had not yet really engaged in management of the centre.

Inspectors found that a lot of what was inspected had only commenced or was at the preliminary and planned stage of commencing at the time of this inspection. As a result of this, a number of areas inspected while improved, remained in non compliance with the requirements of the regulations.

**Judgment:**

Non Compliant - Moderate

**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:**

The provider was aware of their notification responsibilities and indicated on this inspection that a new person in charge notification inclusive of all required supporting documentation would now be submitted to HIQA as a new person in charge was currently transitioning into the centre.

There was some staff ambiguity found on this inspection as to whom the person in charge was as there was a transitioning process happening in this regard.

However on arrival to this centre on this unannounced inspection an acting senior care assistant was in charge and on the morning handover a staff nurse assumed the senior role on shift and allocated tasks accordingly.

**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):**

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

**Findings:**

The findings on this inspection indicated issues regarding the adequate resourcing of this centre which were identified by the provider as still prevalent and not fully implemented.

The provider indicated deficits in resources and personnel as inhibiting service provision. HIQA were submitted representation indicating a service needs analysis had been completed and submitted to the providers funders. This included increased provision of 70 hours per week for social and recreation provision to residents, a full time activities coordinator, a full time nurse, a full time clinical nurse manager and a part time chef.

The provider indicated on this inspection that the activities coordinator had commenced a new person in charge was in place and a final meeting with the HSE was occurring in the week following this inspection to ensure the provision of outstanding resourcing to ensure the centre can move towards regulatory compliance. The inspectors requested this be submitted to HIQA on final agreement with the HSE to assess that the centre has been appropriately resourced in accordance with the service needs analysis.

**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 inspectors found that since the last inspection improvements were evident in that a number of staff had been recruited since the last inspection. However, improvements were still required in this area so as to ensure that there was adequate staffing and skill mix in place in order to meet resident's needs at night time.

Inspectors arrived in this centre at 7:30am and found that the staffing levels in the centre at night time were not adequately ensuring that resident's needs could be met every night.

Three staff were rostered on shift until 22.15hrs every night and there after two staff were rostered on until the next morning. Inspectors found that resident's wishes in terms of personal care could not always be facilitated in the centre due to staffing levels and skill mix some nights.

In addition, inspectors noted that this concern had been raised by staff at a staff meeting held in the centre in January 2017. There were no records to demonstrate how this had been followed up and staff spoken with were not clear about the follow up either. This was discussed at the feedback meeting and specific examples were given to the provider and the person in charge.

Since the last inspection the provider had commissioned a review of the care needs of residents in the centre. From this review the provider intends to consult with the HSE, who are also reviewing the needs of residents in the centre in order to ensure that adequate staffing are available in the centre.

In addition to a number of new health care workers been employed since the last inspection, a nurse had been appointed in January 2017 and an activities co coordinator had been employed two weeks prior to this inspection. As outlined earlier in this report, additional recruitment was also planned to include an addition of 70 hours healthcare support staff each week, a fulltime clinical nurse manager, another registered nurse and a part time chef for the centre.

A planned and actual staff rota was maintained in the centre. Improvements were required in this so as to ensure that all staff grades were included on the rota. The staffing rota included a minimum of six staff on duty from 7.30hrs to 20.00 hrs every day. An additional staff member was also rostered on who had oversight over the centre. This staff was either a staff nurse or a senior support staff.

Inspectors found that between Monday to Friday there was a person in charge, a service coordinator and a clinical nurse manager (CNM) all of whom worked nine to five.

Improvements were noted in staff training specifically around dysphagia. However, the records available in the centre were not complete and the provider and person in charge agreed to submit full and complete training records after the inspection.

The records pertaining to agency staff employed in the centre were not available for review at this inspection. This issue was actioned on the previous inspection.

**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):**

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

**Findings:**

Overall, inspectors found improvement in staff knowledge on the written operational policies as required by Schedule 5 of the regulations. However, inspectors found that gaps still remained in the maintenance of the documentation.

The centre had implemented a 'policy of the month' system since February 2017 whereby staff were required to read and familiarise themselves with the contents of the chosen policy. The chosen policy was displayed in the staff office and staff interviewed referred to the visitors policy and CCTV policy that had featured as the policy of the month in the previous months. Furthermore, policies featured as a standing agenda item in staff meetings.

Inspectors found that some policies and procedures had not been reviewed and updated. For example, the centre's risk management policy was not up-to-date. Management reported that plans were actively in place to ensure all policies were appropriately reviewed.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Conor Brady  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority



**Health Information and Quality Authority  
Regulation Directorate**

**Action Plan**



**Provider's response to inspection report<sup>1</sup>**

<b>Centre name:</b>	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
<b>Centre ID:</b>	OSV-0003441
<b>Date of Inspection:</b>	01 April 2017
<b>Date of response:</b>	03 May 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:**

Appropriate and consistent staffing arrangements were not in place at all times to ensure that each resident's right to privacy and dignity during the provision of intimate and personal care was respected.

**1. Action Required:**

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

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

PIC conducted full Roster Review – Completed 03/04/2017

PIC consulted with individual residents to determine preference in intimate/personal care – 03/04/2017

Roster amended to include availability of female carer until 22:15 hours to meet with identified care needs at night time. – 03/04/2017

**Proposed Timescale:** 03/04/2017

**Theme:** Individualised Supports and Care

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

Staff were unaware of some of the systems implemented to support residents to manage their finances at all times.

**2. Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

Individual Money Management Plans for all residents reviewed/updated and implemented – 01/05/2017

All staff made aware of residents requirements for support to manage financial affairs.

Care plans amended to reflect the above.

Protocol for use of safes in rooms developed and implemented – 01/05/2017

**Proposed Timescale:** 01/05/2017

**Theme:** Individualised Supports and Care

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

The level of satisfaction was not recorded in response to the outcome of some complaints.

**3. 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:**

Complaints process in service reviewed 22/04/2017  
Satisfaction following complaint form introduced – 28/04/2017  
All complaints will be reviewed and monitored to ensure residents satisfaction with outcomes by the Manager and Care Coordinator on a monthly basis – Commenced 02/05/2017

**Proposed Timescale:** 02/05/2017

### **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:**

Residents were not been facilitated to meet friends in the wider community in line with their wishes.

#### **4. Action Required:**

Under Regulation 11 (1) you are required to: Facilitate each resident to receive visitors in accordance with the resident's wishes.

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

All Individual Care Plans updated to reflect family and personal relationships in line with resident wishes – 19/05/2017

Future Social Planning assessments completed by Activity Coordinator and key workers for 8 residents -01/05/2017

Activity Coordinator meeting with key workers and residents to determine resident wishes on a weekly basis.

PIC and Activity Coordinator commenced monthly meeting to monitor and review progress – 01/05/2017

**Proposed Timescale:** 19/05/2017

### **Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

There was limited activities available for residents when they remained in the centre during the day.

#### **5. Action Required:**

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

Activity Plans for residents who remain in centre completed by Activity Coordinator – 02/05/2017

New activities already implemented include Chair Yoga/Internet based interests, crafts and group games and activities, pet therapy and support to access and read daily newspapers.

PIC will monitor and review with support of monthly meeting with Regional Manager  
All residents expressed interests will be planned and catered for by 19/05/2017

**Proposed Timescale:** 19/05/2017

**Theme:** Effective Services

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

Personal plans did not outline who was responsible for the objectives set and within what time frames.

**6. Action Required:**

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

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

All Care plans to be reviewed by the Activity Coordinator/key worker and resident by 19/05/2017

Care plans updated by 31/05/2017

New arrangements in place to include named key worker and relevant Senior Care Worker have identified responsibility for ensuring stated objectives are met.

PIC to monitor progress on a monthly basis

**Proposed Timescale:** 31/05/2017

**Theme:** Effective Services

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

It was not clear how personal plans would be reviewed in order to assess their effectiveness.

**7. 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:**

All personal plans to be reviewed on a monthly basis as part of ongoing 1:1 meetings with residents and keyworkers – Commencing 01/06/2017  
Monthly monitoring by identified Senior Care Worker.  
Oversight and assessment of the effectiveness of plans will be provided by the PIC and Service Coordinator.  
Further monitoring will be provided during the monthly Quality Partner visit.

**Proposed Timescale:** 01/06/2017

### **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Unauthorised access to the centre by unauthorised persons has occurred again in this centre. This did not assure that appropriate safeguarding arrangements were in place to protect all residents.

**8. 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:**

Review of building security completed by Service Coordinator and PIC 24/04/2017  
Quotes obtained for works to increase security at front door area 28/04/2017  
Contractor agreed to implements works to front door area.  
PIC to meet with individual resident/family and advocate to discuss security issues on 05/05/2017

**Proposed Timescale:** 19/05/2017

### **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:**

Residents are not fully supported to participate in employment. There was no assessment or plans in place to support education, training and employment for residents.

**9. 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:**

Individual assessments for all residents support needs re-education/employment and

training commenced by Activity Coordinator/key workers on 16/04/2017  
PIC to meet on a monthly basis with the Activity Coordinator to monitor and review outcomes.

**Proposed Timescale:** 31/05/2017

### **Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Appropriate healthcare in relation to peg management was not consistently recorded and monitored in line with the centre's policy on the management of gastrostomy tubes.

**10. Action Required:**

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

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

Personal plans amended to reflect individual's need and arrangements in relation to peg management on 28/04/2017.

Operational procedure for management of Gastrostomy tube to support the current documentation included in care plan on 02/05/2017

Ongoing review and monitoring of documentation will be provided by the CNM and reviewed by the PIC on a monthly basis.

**Proposed Timescale:** 02/05/2017

**Theme:** Health and Development

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

Effective assessments and arrangements had not been fully implemented to support residents in buying or preparing meals as appropriate to their ability and preference.

**11. Action Required:**

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

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

In line with Future Social Planning Assessments – all residents who express an interest/desire to buy, cook and prepare their own meals will be facilitated to do so.

**Proposed Timescale:** 07/06/2017

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement of purpose was not accurate and needed to be revised and updated.

**12. Action Required:**

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

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

Statement of purpose amended and forwarded on 03/04/2017

**Proposed Timescale:** 03/04/2017

**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:**

While performance management had commenced it was not yet completed for all staff.

**13. Action Required:**

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

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

Performance management system reviewed and amended to fit purpose 28/04/2017.

New staff supervision/mentoring form introduced – 28/04/2017

Supervision and Support meetings for all staff commenced on 01/05/2017 on a six weekly basis.

Meeting frequency will be reviewed following the ratification of the Support and Supervision Policy at the Joint Working Group with the Unions.

Monthly meetings between the PIC and Regional Manager commenced 10/04/2017

**Proposed Timescale:** 01/05/2017

**Theme:** Leadership, Governance and Management

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

A new person in charge had commenced but was in situ only a number of days. While improvements were noted in some area's of service provision other areas had only marginally changed since the previous inspection.

**14. 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:**

Meetings with full staff group commenced on 06/04/2017 and will continue on a monthly basis

Management meetings commenced on 20/04/2017 on a monthly basis.

Role profile reviews and amendments for Senior Care workers commenced on 20/04/2017 and ongoing.

Implementation plans previously submitted will be reviewed and implemented as from 10/04/2017

PIC will review need and personal plans and monitor practice on an ongoing basis.

**Proposed Timescale:** 20/04/2017

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

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

While steps have commenced the provider has yet to fully evidence the provision of all additional resources outlined on the representation made to HIQA.

**15. 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:**

Review of Care needs by HSE staff completed.

Provider is meeting with the HSE on 10/05/2017 to discuss business case in relation to additional funding and resources.

Recruitment of additional staff as outlined in the submission has progressed with additional posts being advertised and shortlisted.

**Proposed Timescale:** 10/05/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The staffing levels in the centre at night time were not adequately ensuring that residents needs could be met every night.

**16. 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:**

Reviewed staffing levels for evening and night period – 04/04/2017

Amended roster to reflect resident need – 04/04/2017

Review of resident need at night time initiated on 28/04/2017

PIC to consider outcome of review and amend roster as required to meet any identified need – 31/05/2017

**Proposed Timescale:** 31/05/2017

**Theme:** Responsive Workforce

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

The rota did not indicate the grades of staff working.

**17. 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:**

Roster amended to include grades – 28/04/2017

**Proposed Timescale:** 28/04/2017

**Theme:** Responsive Workforce

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

This information was not available for agency staff.

**18. 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:**

All relevant information for agency staff now in place – 21/04/2017

**Proposed Timescale:** 21/04/2017

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

The centre's risk management policy was not up-to-date on the day of inspection.

**19. Action Required:**

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

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

Risk Management Policy reviewed and updated -20/04/2017

**Proposed Timescale:** 20/04/2017