Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Cara Cheshire Home
Centre ID:	OSV-0003441
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Violet Lennon
Lead inspector:	Conor Brady
Support inspector(s):	Emma Cooke
Type of inspection	Unannounced
Number of residents on the date of inspection:	15
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
04 November 2016 07:45	04 November 2016 17:30
07 November 2016 09:45	07 November 2016 19:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 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 unannounced inspection was the sixth inspection of this designated centre operated by the Cheshire Foundation (hereafter called the provider). This inspection was of a large premises based in a large park in Dublin City. There were fifteen residents living in this centre at the time of this inspection. The purpose of this inspection was to follow up on a high number of non compliances in this centre with the Regulations and Standards. These non compliances were found on the previous inspection conducted on the 26 May 2016 following which an action plan was submitted to HIQA which outlined the provider's undertakings to improve this centre.

This inspection was carried out in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations (2013), (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations (2013) and the associated National Standards for Residential Services for Children and Adults with Disabilities (2013).

How we gathered our evidence:
As part of the inspection, the inspectors met with a number of residents who resided in this centre. Some residents who communicated verbally spoke to the inspectors and some residents communicated on their own terms with the inspectors. Residents who were communicated with and were observed by the inspectors offered good insights into what it was like to live in the centre. The inspectors met the person in charge, clinical nurse manager, service coordinator, senior care staff, care staff, kitchen staff, drivers, household staff and community employment staff. The provider nominee attended preliminary feedback.

The inspectors spoke with and observed staff and management practices over the course of this inspection. The inspectors reviewed documentation such as policies, protocols and procedures, residents' personal plans and health care plans, incident and accident reports, complaints logs, safeguarding notifications, resident finances and supporting documentation, staff files, training schedules and meeting minutes.

Description of the service:
The provider had a statement of purpose in place that outlined the service that they provided. There were 15 residents accommodated across the centre on the date of inspection and the centre was not accepting new admissions.

According to the centres statement of purpose, support is provided 24 hours per day 7 days per week. Staff supported people with a variety of disabilities including the following: Cerebral Palsy; Multiple Sclerosis; Hydrocephalus; Acquired Brain Injury; and Cerebrovascular Accident (CVA). Often people have secondary disabilities which included an intellectual disability, mental health difficulties or medical complications such as diabetes.

Overall judgment of our findings:
Overall, the inspectors found that this centre provided an adequate standard of care to the residents who lived in this service in a number of areas. However there remained a high number of areas that were not adequately addressed following the last inspection carried out by HIQA. This did not assure HIQA that residents support needs were being appropriately addressed by the provider.

Inspectors had concerns in the areas of resident heath and social care planning and provision, general welfare and development, risk management, safeguarding and resident finances, behavioural support, staff knowledge, training and supervision/appraisal, resources and policy implementation.

The inspector found that a number of failings found on the HIQA inspection

conducted in May 2016 were found again on this inspection demonstrating on-going non compliance with the Health Act and associated Regulations.

All findings of this inspection are discussed in the main body of this 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:
The inspectors found that while some actions issued in respect of the centre on the previous inspection had been addressed further improvements were required in the areas of resident's rights, dignity and consultation.

The inspectors found improvements in the area of resident privacy with a front door bell, automated doors (very recently installed) and visitor's book now providing more security in terms of persons with access to the centre. Residents personal information had been taken down from their bedroom walls and incontinence wear was now stored discretely.

Residents spoken with informed the inspector they were reasonably happy with the service with most residents responding with 'it's okay' when asked about the quality of their service.

The inspector found consultation with residents required improvements. In reviewing meeting minutes the inspector found that resident meetings were not occurring monthly as they were supposed to with some meetings only happening every 3-4 months. This did not demonstrate on-going consultation with the residents.

In addition, the resident's sitting room was observed on this inspection being used for training staff who did not work in this centre by an external trainer. The person in charge highlighted that this occurred as the provider did not have another location to provide this training. This was not found to be respectful of the resident's home.

In reviewing the area of resident finances the inspectors found that a number of residents did not have appropriate control/access to their personal finances. Resident's monies were paid into an account that was a provider account and was not in the residents names. This was a 'pooled' account system that was operated where multiple resident's monies were paid into this account. Local records were maintained by administration staff and these were reviewed. The inspector was very concerned that in reviewing resident account documents that an excess of €1825.79 was not appropriately accounted for. In addition, a resident who was deceased since 2014 still had recorded finances in an account according to this 'pooled' account. While the two administration staff who managed finances locally had some systems in place to manage and record income and expenditure, the overall provider oversight and financial auditing was inadequate based on these findings.

Judgment:
Non Compliant - Major

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.

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 all residents. Inspectors observed residents that used assistive technology supports and appliances to promote their full capabilities. Letter charts were in place for non-verbal residents and used effectively by staff. Staff and residents had developed communication systems along with the input of resident's families. Residents were allocated key workers for continuity of care and on-going communications with the residents families

Communication care plans accurately reflected the systems in place to enable staff and residents to effectively communicate.

Individual communication requirements were highlighted in personal plans and reflected in practice.

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 every day 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):
No actions were required from the previous inspection.

Findings:
Inspectors reviewed systems in the centre and found that some residents had maintained relationships with their families and that the provider had systems in place that ensured families were welcome to visit the centre and be involved in residents care. However the inspector found that improvements were required to link residents with their surrounding community.

The inspectors found that an open day had occurred in the centre to involve families and visitors. Some residents went to the cinema and bowling according to the person in charge. The inspector observed a resident planning to go the cinema with a volunteer on this inspection. However, only six out of the fifteen residents in this centre attended a day service and residents had inconsistent access to their communities with many activities happening in the designated centre as opposed to outside in the community. Many residents were observed remaining in the centre for the duration of this two day inspection. When spoken with and asked what they were doing for the day/evening many residents stated they were not doing anything.

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:
The inspectors found admissions policies were in place and there had been no admissions to the centre since the previous inspection. The person in charge outlined that this centre was not receiving any new admissions. Inspectors reviewed a number of resident contracts for the provision of services and found some inconsistencies with same. For example, a number of residents were paying different amounts for the same service. The inspectors found that one resident was being charged more than other residents because they would not disclose their means to the provider.

In addition, some payments/fees that were collected by the provider from residents were not outlined in the resident's contracts. For example, 'residents leisure monies' that were paid by some residents. When examined this practice was not found to be guided by any organisational policy or procedure and was not outlined in the respective resident's contract for provision of services.

Judgment:
Non Compliant - Major

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:
Inspectors remained concerned with the levels of social care provision demonstrated in

the designated centre on both days of the inspection. Since the previous inspection and as outlined in the provider's action plan response to same, staff met with all residents to set meaningful goals and objectives and such plans were to be reviewed monthly for progress. However, not all resident's goals had been evaluated for progress and it was unclear on some plans as to who was responsible and the actions taken to date in facilitating residents to achieve their goals.

Further improvement was required in terms of a consistent approach to social care planning with residents and ensuring plans were comprehensive and effectively monitored. Improvement was also required to ensure that the plans in place guided staff appropriately and were accessible to residents.

A social needs analysis completed by the service co-ordinator identified that each resident required additional supports ranging from 9hrs-33hrs per week in order for them to achieve the goals and objectives set out in their social care plans. Currently the centre only avails of one volunteer available for 20hrs per week to help residents achieve their goals. Staff acknowledged that some of resident's goals and objectives had not been achieved as a result. This demonstrated an over reliance on volunteers to achieve residents goals.

Inspectors found that not all personal plans were kept under review and were not fully operational. Some social plans did not identify the person responsible for the objectives within the agreed time scale. Inspectors observed that residents and their family members were consulted and involved in reviewing plans, however, inspectors reviewed progress notes whereby a residents family member expressed disappointment that a residents had not achieved their goals and objectives due to a lack of staff available.

On both days of inspection, inspector's observed that many residents spent the majority of their day in the day room which is similar to previous inspection findings. On the first day of inspection, residents were scheduled to go bowling, however, this was subsequently cancelled as a staff member had fallen sick and needed to go home.

Some residents spoken to said that they would go on a social outing once a week but would like to get out more but sometimes there would not be enough staff to bring them out.

A white board based in the activities room outlined activities for Monday - Friday from 09:00hrs to 13:00hrs. A resident voiced that not all activities organised in the activity room would appeal to them in the morning and alternatively they would remain in the centre. Other residents reported that they were happy with the activities provided.

Judgment:
Non Compliant - Major

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:
Overall, the design and layout of the centre was found to be suitable to meet the current profile of residents' individual and collective needs.

The centre is surrounded by extensive grounds and is centrally located with access to local amenities. The building is a two storey building but residents only occupy the ground floor.

The centre has a large dining room, a laundry, kitchen, physiotherapy and occupational therapy area, office spaces, an activities room, a large sitting room, a sun room, landscaped grounds and a patio area. There was adequate additional private accommodation also for residents to spend time in private or with family.

All residents rooms were single and of a suitable size containing hand washing facilities, bed, furniture including wardrobes, chairs and tables, with adequate storage for all residents. One of the bedrooms in the centre had en-suite facilities. Inspectors found a suitable number of toilets and bathrooms available to residents.

There was suitable equipment, aids and appliances in place to support and promote the full capabilities of residents. However, inspectors noted some inappropriate storage of manual handling equipment on corridors. This was brought to the attention of staff at the time of the inspection. The centre was found to be very clean with spacious corridors and painting and decorating was occurring at the time of the inspection. The provider had addressed failings identified on the previous inspections with the centre found to be brighter and cleaner and the lack of hot water issue was now resolved in resident's bathrooms.

Inspectors found suitable arrangements are in place for the safe disposal of general and clinical waste where required and staff were knowledgeable about such arrangements. Adequate facilities were in place for residents to lauder their own if they wished to do so.

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

Findings:
Inspectors found that the management of the area of risk had improved since the previous inspection. The provider had taken a number of steps to ensure substantive improvement in the area of fire safety and evacuation procedures. However further input remained necessary to ensure appropriate staff knowledge in the area of dysphagia.

The inspectors found that risks were assessed in this centre and risk assessments were found in place regarding residents at risk of falls, choking and having seizures. In reviewing a number of adverse incidents the inspectors found a system in place that recorded accidents, incidents and near misses. The inspector found evidence of follow up on a number of areas such as premises and equipment issues, fire alarms (false alarms), and resident falls. However other incidents were not found to be appropriately followed up. For example, care plans for the management of pressures sores were not developed as required.

In speaking with a number of staff about residents' needs inspectors found that some staff presented as very knowledgeable regarding individual residents support needs. For example, specific resident's diabetes, epilepsy and medication needs. However inspectors found that some staff were not appropriately knowledgeable in the area of dysphagia. This was a concern as this area was found to be in major non compliance with the regulations and standards on the previous inspection. While the provider had completed training with staff, not all staff had completed the training.

The area of fire safety had been given increased attention since the previous inspection with drills carried out and action plans implemented to address previous failings.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Inspectors found that there was a higher emphasis placed on the safeguarding and protection of residents and found awareness sessions had been completed with staff and residents since the previous inspection. Residents were found to be reasonably protected by the systems in place however further improvement was required in the areas of protecting residents finances, the management of unauthorised visitors to the centre and the provision of behavioural support for residents requiring same.

The inspector found policies were in place regarding the protection of vulnerable adults and procedures were displayed and up to date with national policy guidance. The provider understood their role in reporting any concerns and or disclosures, allegations or cases of suspected abuse to the relevant statutory bodies. The inspector found adequate measures in place regarding the protection of residents in the centre however as outlined in Outcome 1, the practices regarding the management of resident's finances required further improvements.

In addition, the inspector found unauthorised visitors had accessed the centre on a number of occasions which was a matter under investigation at the time of inspection. In reviewing the accident and incident records it was also found that there had been three recent allegations of staff monies going missing in the centre. However while these matters were being investigated a new security (electronic automated doors) system had been implemented to provide increased security for persons entering the centre.

From a therapeutic and positive behavioural support perspective there was not clinical or therapeutic assessment or oversight provided for residents' requiring same. The inspectors reviewed incidents (including behavioural) and resident's personal plans and discussed this area with the person in charge in some detail. Correspondence was seen requesting behavioural assessment from another provider which was declined. Aside from this, there was no behavioural support planning or therapeutic guidance regarding the support of residents in 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:
The inspectors found a log of incidents and accidents was maintained in the centre and notifications were submitted to the Chief Inspector as required.

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):

Findings:
Overall inspectors found that resident's opportunities for new experiences, social participation, education, training and employment were not always facilitated and supported.

At the time of the inspection, no resident was actively involved in any education or employment scheme. Staff stated that this had all been offered but residents declined. Personal plans and documentation did not reflect this. 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 such as 'go for lunch' and that there was no meaningful assessment process to establish each resident's educational, employment and training goals. There was no evidence to suggest that these opportunities had been explored/re-explored with residents.

A resident had expressed an interest in attending painting classes as part of their assessment but this was not implemented as a goal or objective and documentation did not reflect why this was not explored or followed up. Equally another resident told inspectors that they would like to get involved in cooking but staff stated they were unaware of this. Inspectors acknowledged the varied age range of some residents and noted how a retired resident was supported at times to engage in gardening activity which the resident enjoyed.

Some residents voiced that they had opportunities to participate in activities but not as often as they would like and that this would heavily depend on staffing available. Some residents were facilitated to integrate into their communities in accordance with their wishes. For example, the centre had appropriate staffing arrangements in place to accommodate two residents to go out every Friday evening to watch a band play.

Inspectors found that more meaningful proactive engagement was required from staff to support residents in this area as some staff stated that they would rely on residents to come to them and identify what they would like to do. Some staff spoken to were unaware of any arrangements to support residents to undergo training and attend college and identified that this was the role of the occupational therapist.

On review of the centre's policy in relation to supporting people to access training, education and developmental opportunities, the policy identified that all staff are responsible for supporting resident's in this area. However, the policy lacked clear guidance and direction for staff to support residents in identifying and achieving personal goals.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Inspectors acknowledged that some improvements to the healthcare findings on the previous inspection had been implemented. However, some staff lacked the necessary knowledge, understanding and management of resident's conditions and associated healthcare needs. Furthermore, gaps in resident's healthcare documentation remained.

Inspectors reviewed a number of personal plans including documentation relating to the residents assessed needs and healthcare plans. Healthcare plans were developed for the majority of residents' assessed needs. However, inspectors found that some staff knowledge in relation to specific healthcare conditions was limited and some staff did not demonstrate the clinical expertise to appropriately care for residents. For example, some staff had no knowledge of the monitoring of symptoms or care required for identified conditions.

Policies and guidelines had been developed to guide and support the care of residents requiring PEG (percutaneous endoscopic gastronomy). Care plans reviewed reflected aspects of the policy and staff were familiar with some aspects of the care plan. However, staff were unaware of the documentation available to support daily checks and facilitate adequate communication about the care and management of PEG tubes. Care plans lacked necessary information about PEG tubes that would facilitate ease of transfer to hospitals in emergency situations as directed by care plans. Inspectors noted an over reliance by staff on residents family members in dealing with the emergency management of such medical devices.

Inspectors found the details in some healthcare plans were not implemented in practice. Additionally some care plans had not been updated to reflect changes. Inspectors also found that some individual resident's health needs were not appropriately assessed and evaluated by the care provided in the centre. For example, a resident that had developed pressure sores did not have an updated care plan in place that outlined the assessment, management, treatment and evaluation of the pressure sore despite a skin integrity assessment identifying the need for on-going monitoring and recording as the resident is at risk due to an underlying condition.

Inspectors found that residents were not supported on an individual basis to achieve and enjoy the best possible health due to the limited interventions some staff were able to carry out for resident's with specific healthcare needs. This impacted on resident's health and social care outcomes. At the time of the inspection, ongoing training was being carried out to up skill staff on the interventions required to manage certain healthcare conditions. However this was a finding of the previous inspection of this centre.

Residents were prevented from preparing their own meals as residents did not have any access to the kitchen area. Snacks and drinks were available to residents in the dining area. Resident's spoken with said that the food and choice was 'okay' and that they were supported during meal times.

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. Improvements were noted from the last inspection whereby residents have access to some allied health care professionals in order to meet their needs, however improvements were still needed in relation to timely access for some residents. For example, dietetic support for a resident assessed as requiring same.

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

Findings:
Overall inspectors found improvements in medication practices within the centre since the last inspection. Staff stated that a full review of resident's prescriptions had recently taken place.

Inspectors reviewed prescription and administration records for a number of residents. Generally, prescriptions contained the required documentation and information; however, allergies were not recorded on one medication sheet reviewed.

Inspectors reviewed practices around the use of PRN (as required) medications as this had been an area of non compliance at the last inspection. A sample of resident's prescriptions were reviewed. Overall, the majority of PRN medications indicated the reasons for use on resident's prescriptions. Two PRN medications used for applying to the skin did not have the maximum dosage stated. Staff identified the right measures and actions they would take to rectify the situation and to ensure the resident would not be at risk.

Inspectors observed the morning medication round. Only senior care workers that had received medication administration training signed off as administering medication. Staff followed appropriate medication management practices and were knowledgeable about the drugs being administered. However, inspectors observed staff being interrupted twice whilst trying to prepare and administer medication.

Medication was stored securely in a locked press within an office accessible by a coded keypad system and the keys were kept on a senior staff member at all times. Systems were in place for out of date or returned medicines whereby they were stored in a locked press and segregated from other medicinal products and collected weekly, signed and accounted for and returned to the pharmacy.

Inspectors reviewed the centre's updated medication management policy which had written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Some improvements in the policy were discussed with management at the time of the inspection.

Only one resident took responsibility for administrating their own medication, the remaining residents were happy to allow staff manage their medications. Inspectors reviewed the appropriate assessment carried out by the nurse to support this resident to self administer their medication. Another resident was undergoing this assessment at the time of inspection also.

Judgment:

Substantially 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:
Inspectors found a written statement of purpose was in place that outlined the services provided in the designated centre. The provider highlighted this document may change following recent contact with the providers funders.

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:
The inspectors found a person in charge was in place and this designated centre had a clear management structure that was outlined in the statement of purpose. However substantive improvements were required to ensure that the service provided is appropriate to residents' needs and consistently and effectively monitored in accordance with the requirements of the Regulations and Standards.

The inspector reviewed a new Standard Operating Procedure (November 2016) which

outlined key changes in the provider's structure and associated roles. There was a new provider nominee identified for this centre since the previous inspection who attended preliminary feedback.

Inspectors found that a person in charge was in place and was supported in the role by a clinical nurse manager and a service coordinator.

While auditing and quality review was taking place further improvement was required to ensure audit findings translated into improved quality of life for all residents living in the centre. For example, the provider had completed a 2015 annual review and unannounced inspections in 2016 which generated action plans. In reviewing these audit tools the inspector found that areas such as residents personal plans, residents finances, health and safety, safeguarding, advocacy/consultation, and staff training were all identified as areas that needed to be improved and many were marked as a 'work in progress'.

The inspectors found that while improvements were evident in some areas, the centre remained in non compliance with the requirements of the regulations as evidenced within this report. Inspectors found that while auditing was taking place, the local and operational implementation of action plans based on audit findings was inadequate to ensure sustained improvements for residents in accordance with the regulations and standards.

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:
There were systems in place to notify the Chief Inspector whereby the person in charge was absent from the designated centre for prolonged periods of absence.

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:
The centre demonstrated that while adequate resources were evident regarding facilities, transport vehicles and equipment, further improvements to staff resourcing were required in this centre. The provider stated that a needs analysis had been completed and submitted to the providers funding body and this was in process. The service coordinator indicated the service was not currently resourced to meet all of the resident's health and social care needs. The area of staff resourcing will be discussed further under Outcome 17.

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:
Inspectors found that the actions on the previous inspection were not appropriately addressed.

There remained a vacant nursing position which the provider has not successfully filled over the past two years according to the person in charge. This has resulted in a lack of an appropriate skill mix in the centre in terms of clinical oversight on the centres roster.

Inspectors were not satisfied that the staffing compliment was appropriately addressing

resident's health and social care needs. In observing practices, speaking with residents, staff and management and reviewing the centres rosters, the inspectors found gaps in staff numbers in the centre. For example, given the profile and support needs of residents many required 2:1 and some 3:1 with personal care and mobility support. Inspectors observed residents being supported in the early morning period and monitored the time it took for all residents to be supported to get up, have showers and have breakfast.

While inspectors were informed that some residents chose to remain in bed the timeframe to support residents throughout this period extended into lunchtime. Inspectors were informed that some staff had called in sick on the day of inspection and another left work sick over the course of inspection. The service coordinator worked as a care staff member in these instances. At the busiest period (morning) the staffing compliment was observed to be 6:15 (day-time) and at night this dropped to 2:15. Some residents spoken with highlighted that they would like to have more frequent showers but staffing levels prevented same on some occasions.

A staff training record was reviewed that included manual handling, fire safety, dysphagia, first aid and adult protection. Inspectors reviewed personnel files, training records and training attendance sheets. While some improvements were evident some staff remained untrained in certain mandatory areas. As outlined earlier in this report the area of dysphagia training had not been delivered to all staff since the previous inspection. In addition a number of staff were found to be 'due' training in key areas and a volunteer living in the centre did not have up to date training evident in fire safety, dysphagia or adult protection.

Agency staff training records and personnel information was not maintained in the centre and was not available on this inspection.

There had not been improvement in performance management since the previous inspection with the person in charge highlighting that this was 'in process'. There was not a system of supervision or performance development/appraisal in place for staff at the time of this inspection. This is highlighted under Outcome 14 in the accompanying action plan.

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:
Overall inspectors found that improvement was required to ensure policies were reviewed, up to date, accessible and implemented.

While there were operational policies and procedures in place some gaps were evident in the maintenance of the documentation and staff knowledge of policies whereabouts and content required improvement. Inspectors found some policies lacked detail and clear direction to guide staff. For example, the policy in relation to supporting people to access training, education, and developmental opportunities did not guide staff on the assessment process, frequency of assessment and evaluation and resources available to optimise resident's ability to engage in such opportunities.

Many staff were unaware of existing policies in place to support and guide practice and could not locate certain policies when asked for same. When some outstanding policies in relation to Schedule 5 could not be initially located, staff were unaware whether such policies existed or whether they are stored elsewhere. For example, staff did not know if the centre had a policy in relation to Food, Nutrition and Hydration, Communication, Visitors, Resident's personal property and finances and CCTV.

Management later sourced any outstanding policies on the centre's intranet and advised that all up to date policies were accessed this way. However it was clear that further training was required to ensure the centres policies were accessible, understood and implemented.

The directory of residence was maintained up to date and there was satisfactory insurance in place to ensure against accidents and injury to staff.

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[1]

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003441
Date of Inspection:	04 and 07 November 2016
Date of response:	13 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:
Consultation meetings with residents were not occurring monthly as prescribed.

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

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

Please state the actions you have taken or are planning to take:
• Service Manager/designate will conduct minuted residents' meetings once per month.

• Service Manager/CNM/Service Coordinator will conduct one to one meetings with residents once per month utilizing one to one record to document same.

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:
The resident's home (sitting room) was being used as a training facility to a cohort of the provider staffs who did not even work in the designated centre.

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

Please state the actions you have taken or are planning to take:
• Use of the residents' sitting room for training purposes will cease.

Proposed Timescale: 28/02/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Resident's monies were put into an account that was not in the residents name. There were anomalies found in accounts whereby resident's monies were kept by the provider. This did not demonstrate a clear and transparent system of financial management of resident's finances.

3. Action Required:
Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

Please state the actions you have taken or are planning to take:
• Use of the pooled residents leisure money account will cease.

• Residents will be supported to avail of personal safes or personal bank accounts.

• Service manager will meet with residents (and their families, if applicable), and bank institutions regarding their own access to their account and support them in management and control of their finances.

Proposed Timescale: 31/03/2017

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:
The inspector found that residents did not have consistent links and relationships with their wider community.

4. 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:
• Personal social plans will be reviewed and further developed by named Key Workers to ensure they consist of SMART goals in relation to family and personal relationships and links to the community.
• Additional support hours are now available in the afternoons to facilitate residents' access to social activities in the community. Engagement is ongoing with the HSE nationally to acquire additional funding to increase these hours further.
• All newly recruited Care Staff will be required as part of the role profile to hold a full driving licence to drive residents occasionally. Existing Care staff will be supported around transport vehicle training to include wheelchair clamping

Proposed Timescale: 30/06/2017

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:
All aspects of fees paid to the service regarding 'resident's leisure monies' were not outlined in resident's contracts.

5. 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:
• Until such time that alternatives (personal safes or personal bank accounts) are in place service manager will amend residents' contract (if applicable) to outline the service support in relation to "residents' leisure money".

Proposed Timescale: 31/01/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were not appropriate arrangements in place to meet residents social care needs.

6. 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:
• Keyworkers to review personal plans for their named individuals and ensure persons' responsible and timeframes are included within.
• Recruitment for additional relief staff and 1.2 WTE care support workers is underway.
• Service needs analysis is completed annually and more often if needed.
• Engagement has commenced and is on-going nationally and with CHO at local level to ensure adequate funding to meet assessed needs.

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:
The effectiveness and implementation of plans was not assessed and found to be appropriately addressing residents needs.

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 and assessed on at least a 3 monthly basis by the Quality Partner/designate who will document same. Additionally, effectiveness of plans for meeting residents' wishes will be discussed in their monthly one to one meetings with Service Manager/Coordinator/CNM.

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:
Plans were not found to outline clear objectives with person accountable to support residents in achieving same.

8. 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:
• Senior Care Worker with the Service Coordinator will be responsible for monthly oversight and review of all social plans to monitor progress, responsible persons, timeframes, and actions.
• All personal plans will be reviewed and assessed on at least a 3 monthly basis by the Quality Partner/designate who will document same. Additionally, effectiveness of plans for meeting residents' wishes will be reviewed in their monthly one to one meetings with Service Manager/Coordinator/CNM.

Proposed Timescale: 31/03/2017

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:
The risk of dysphagia was not appropriately responded to since the previous inspection.

9. 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:
• Dysphagia training for staff who have not completed it will take place in February 2017 by the Speech and Language Therapist.

• Ongoing refresher sessions by CNM with small groups or individual staff are underway to ensure knowledge of dysphagia and provide support for continuous learning of same.

Proposed Timescale: 28/02/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no therapeutic involvement, assessment or review in resident's personal planning process regarding positive behavioural support.

10. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
• Referrals have been requested via the GP or local services for therapeutic interventions for any resident who requires it.

• Service manager has completed a behavioural support plan/guidance regarding the supports required in the interim.

Proposed Timescale: 31/01/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Safeguarding arrangements in place regarding residents finances and unauthorised person accessing the centre required review.

11. 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 the individual supports provided to residents in relation to their management and support of their finances/visitors if required will take place and any amendments required in how the service responds to them will be implemented. Individual 1:1 meetings in relation to these matters will begin/take place in the monthly one to ones between residents and Service Manager/CNM/Service Coordinator or more often if necessary.

• A security system is in place, all visitors are required to use front door bell to access the service and a log in/out book is insitu.

Proposed Timescale: 31/01/2017

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:
There were not opportunities for residents found evident and further guidance, encouragement and support was required in this area.

12. 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:
• CE supervisor is updating Service Coordinator on a weekly basis of all education, training, and employment opportunities available to residents in the locality. This information will be provided to appointed Key Workers and support will be provided to residents by them to participate in activities of their choice.

• Training will be provided to all care staff in understanding the Key Worker role. Training in social role and SMART goal setting will be delivered by the Service Quality Partner over three reflective modules.

• The message that meeting the social care needs of residents is the responsibility of all staff will be a standing agenda item in all staff meetings.

Proposed Timescale: 30/06/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate health care was not provided to a number of residents reviewed. The care planning and response to PEG feeding was not adequate.

13. 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:
• Care plan regarding PEG was updated to reflect changes.

• Full time staff nurse has been recruited (accepted post 11/1/17) and will work alongside existing CNM.

• CNM/Nurse will conduct small group or individual information/refresher sessions in individuals' health care plans and healthcare conditions to ensure/monitor staff knowledge and provide support for continuous learning.

• Requirements as stated in the Cheshire Ireland Policy and SOP for Management of Gastrostomy tubes to remain as a standing agenda item in all staff handover meeting. Including the importance of the essential documentation being completed.

• Local senior management are reviewing Peg feed record charts at least once per day to ensure compliance.

• CNM to review and update all personal plans to ensure staff have required information to manage clinical conditions, including any identified changes, as required.

• Dietician is in place for individual with PEG feeding.

Proposed Timescale: 31/03/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not involved in aspect of meal preparation and did not have access to a kitchen area to prepare meals.

14. 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:
• Cheshire Ireland's Health and Safety officer to conduct an assessment on 22nd February 2017 to establish if it is feasible for residents to be more involved in meal preparation.

• If it is deemed to not be feasible nor practicable those residents who wish to be involved in shopping, preparing food, cooking will be supported to consider and avail of appropriate alternative solutions eg. Cooking classes

Proposed Timescale: 31/03/2017

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:

Ensure clarity on medicines prescription guidance and protected time for the uninterrupted administration of medications.

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

Please state the actions you have taken or are planning to take:
• Residents' prescription sheets were reviewed by the GP in December 2016 and any clarity required on medications for skin were sought.

• Staff administering medicine wear a visibility jacket and all other staff on duty will be reminded to ensure no interruptions are to occur during a medicine round. This will be a standing agenda item at staff meetings and staff handovers. A written protocol is in place to support this.

Proposed Timescale: 31/01/2017

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:
There was not a system of performance management and development in place for staff.

16. 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 meetings have commenced. One to one meetings to occur with staff on a 3 monthly basis or more often if needed. Details are recorded and held in personnel files.

Proposed Timescale: 31/03/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of this centre did not ensure that all aspects of the service provided

was appropriate to residents' needs and was consistently and effectively monitored.

17. 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:
• Calendar of internal audits and bi-annual provider audits is in place for 2017.
• Each Audit/Review will generate an action plan. Each action plan will be uploaded to the Senior Team shared file. Each action will be assigned to a member of the senior team, regional partner and time-framed. All actions will be reviewed at the weekly senior team meeting.
• A part of each periodic audit will be to check the follow through on a number of the actions from the last periodic audit.
• Actions stemming from annual review, audits, HIQA inspections etc. will be monitored by region's Clinical Partner, Quality Partner, and HR Partner. Calendar of monthly visits by partners to services is being finalized. Actions in relation to Health and Safety and Learning and Development matters will be implemented with the relevant personnel as needed.

• Written communication will be provided back to Provider Nominee following partner visits on service and status of actions.

• Actions will be monitored by Person in Charge and overseen by Provider Nominee and will be a standing agenda item in their recorded monthly support and supervision meetings.

• Learning points will become a standing agenda item on staff, service, and regional meetings to promote sustained improvements for residents.

Proposed Timescale: 31/03/2017

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, person in charge and service coordinator indicated deficits in resources and in particular personnel as inhibiting service provision. Inspectors were informed a service needs analysis was being completed at the time of inspection and was being submitted to the provider's funders.

18. 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:
• Recruitment for additional 1.2 WTE care support staff has been filled. Additional support hours are now available.
• Full time staff nurse has been recruited (accepted post 11/1/17) and will work alongside existing CNM.
• Service needs analysis is completed annually and more often if needed. This information will inform funding requirements in Service Level Agreements with HSE.

• Engagement has commenced and is ongoing nationally and with CHO at local level to ensure adequate funding to meet assessed needs.

• Recruitment through the CE scheme will take place for an Activities Coordinator to support in meeting the social care needs of residents. Provider Nominee will seek to have this role be a funded part of service provision.

Proposed Timescale: 31/03/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff numbers and skill mix were not in line with residents needs.

19. 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:
• Recruitment for additional for 1.2 WTE care support staff has been filled. Additional support hours are now available.
• Full time staff nurse has been recruited to support (accepted post 11/1/17) and will work alongside existing CNM.

• Service needs analysis is completed annually and more often if needed. This information will inform funding requirements in Service Level Agreements with HSE.

• Engagement has commenced and is ongoing nationally and with CHO at local level to ensure adequate funding to meet assessed needs.

• Recruitment through the CE scheme will take place for an Activities Coordinator to support in meeting the social care needs of residents. Provider Nominee will seek to have this role be a funded part of service provision.

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:
Agency staff documentation was not maintained by the person in charge to ensure these staff met the requirements of the Regulations.

20. 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 evidence of agency care staff and nurse documents in relation to qualifications and training are now available in the service. Any new agency care staff/nurse scheduled to work will not commence duty until evidence of their documents are provided to the service.

Proposed Timescale: 08/11/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of staff/volunteers were not up to date with mandatory training.

21. 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:
• Volunteer completed mandatory training on 22nd November 2016. Program of mandatory training for staff member who has just returned from long term sick leave is underway.

Proposed Timescale: 28/02/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Schedule 5 policies were not appropriately implemented as some staff members were not aware where they were or what was in them.

22. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
• All Schedule 5 policies are available in the service

• All policies relevant to the service are available in The Policy Folder held in the care office and this will remain as a standing agenda item in staff meetings. Similarly that all policies are available on the Cheshire website to which all staff have access.

• Service will implement a "Policy of the Month" whereby staff will be required to read and familiarize selves with contents of the chosen policy. Any clarity or questions re same can be discussed in the care staff meetings or with line management.

Proposed Timescale: 31/01/2017