

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Rathfredagh Cheshire Home
Centre ID:	OSV-0003449
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Patrick Quinn
Lead inspector:	Cora McCarthy
Support inspector(s):	Louisa Power
Type of inspection	Announced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	7

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 19 June 2017 09:30 To: 19 June 2017 17:45

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 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the Inspection:

This was an inspection carried out to monitor compliance with the regulations and standards and to inform a registration decision. The previous inspection was on 19th July 2017 and, as part of the current inspection, inspectors reviewed the actions the provider had undertaken since the previous inspection. The significant improvements noted at the previous inspection in this area were seen to be sustained on this inspection.

How we gather our evidence:

As part of the inspection, inspectors met and interacted with residents who reported that they were happy with life in the centre, and that staff were kind. Inspectors also spoke with staff and managers and reviewed documentation such as policies and procedures, risk assessment and future planning draft documents.

Description of the service:

The provider must produce a document called the statement of purpose that explains

the service they provide. Inspectors found that the service was being provided as it was described in that document. The centre comprised a large period two-storey house and separate accommodation in courtyard buildings in a rural location approximately six kilometres from a large market town. The service is available to adult men and women who have primarily a physical disability or neurological condition.

Overall findings:

Inspectors found that significant improvements had been made with regard to the governance and management of the centre since the last inspection. Adequate measures had been put in place to ensure the safety of residents who received enteral nutrition (nutrition delivered via a tube). Fire safety measures were adequate and robust. Medicines management practices were safe. There was a new clinical nurse manager overseeing the clinical governance and there were sufficient systems in place to ensure appropriate clinical management of the centre.

The inspector was satisfied that the provider had put systems in place to ensure regulatory compliance. All the actions emanating from the previous inspection had been satisfactorily completed and improvements noted in the following areas:

- safe and suitable premises (outcome 6)
- adequate fire safety precautions (outcome 7)
- healthcare needs (outcome 11)
- consistent management of enteral nutrition (outcome 11)
- safe medicines management practices (outcome 12).

Improvements were required in the following area: staff training in positive behaviour support (outcome 8); staff training in first aid, dysphagia and safe moving and handling.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Overall, residents privacy and dignity was respected. Residents had access to advocacy services and information about their rights and there was a clear complaints system in place. However, it was identified on inspection that meal options were decided for some residents by the catering staff and that some residents did not have choice in this area.

Residents had access to advocacy services as evidenced in minutes of regular advocacy meetings which addressed concerns such as the move from the designated centre to the community. This issue was addressed by inviting a former resident, currently living in the community, to discuss this matter with the residents accommodated in this centre.

On review of resident's files it was noted that there was a very robust and accessible complaints management system in place and evidence that complaints were dealt with in an appropriate manner. Initially complaints were addressed through a preliminary screening of a complaint and feedback form; for example; one complaint stated that a new fire emergency light was too bright; this was addressed by contacting the relevant fire company and the light was subsequently dimmed. Complaints were addressed either locally or escalated as necessary and there was also an appeals process in place that was clear and transparent.

Inspectors observed during the inspection that staff members were respectful of residents and supported them in a manner that maintained their dignity; this was particularly evident during mealtimes. However, improvement was required to ensure that all residents could make choices around meal options. It was identified on inspection that meal options were decided for some residents by the catering staff.

There was evidence of residents' consultation with regards to discussion around moving to the community.

Residents were supported to exercise their political and religious rights. Mass was celebrated on a weekly basis. Residents could chose whether to participate in religious services, according to their individual wishes.

Judgment:

Substantially Compliant

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:

There was a policy on communication with residents. However, it was not evident that residents' individual communication requirements were based on an assessment of communication needs by an appropriate health professional. This will be further referenced under outcome 5.

Residents' communication passports contained pertinent information, for example, that staff speak 'slowly and in short sentences'. The staff knew the residents well and were familiar with gestures used by residents to communicate. Individual communication requirements were noted in personal plans and additional individualised supports had been put in place to support one resident's communication. Some residents availed of assistive technology to support them with communication and attainment of goals. However, it was noted on inspection that not all residents who were non-verbal were assessed or facilitated to communicate in an alternative manner through technology or visual aids.

Inspectors noted improvements in communication strategies for one resident. They now had a checklist of non-verbal pain indicators and where behaviour was identified as a means of communication. A staff member with the requisite skills to communicate with this resident was called upon by staff to clarify the needs or concerns of the resident.

The residents' preferred form of communication was also used for the purpose of fire evacuations and fire drills and for translation of documents.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

A comprehensive needs assessment was carried out which included a health assessment, speech and language (SALT) assessment and occupational therapy (OT) assessment. However, as previously mentioned under outcome 2, a comprehensive assessment of one resident's communication needs was not evidenced.

Where sensory needs were identified for individual residents by the OT, a recommendation, for example, obtaining a sensory bag for a resident, was implemented. Each resident had a written personal plan which outlined 'who I am' in a visual format. However this information was not readily available to residents and staff.

Inspectors reviewed a sample of residents' personal plans and saw that a multidisciplinary team meeting was convened for each resident on a quarterly basis and the meeting minutes demonstrated that the personal plan was reviewed at this meeting. Inspectors reviewed a sample of plans and saw that many of the plans were signed by the resident or their representatives indicating their involvement in their personal plan. At the previous inspection, it was identified that further improvement was required in relation to the setting of goals when the personal plan was reviewed, particularly long term goals. On this inspection, inspectors reviewed a sample of personal plans and saw that although goals were outlined in the personal plans, they were task orientated, for example, a hairdresser appointment, and not outcome-focused goals.

A residents' annual review was also facilitated and resulting from this it was identified, for example, that a resident required a new wheelchair (December 2016) which required assessment by an external provider. To date, the resident had an assessment and had a trial of a new wheelchair scheduled for July 2017. There was evidence that residents' wheelchairs were checked and maintained; the brake and tilt lever of one wheelchair was repaired.

Some residents was also working with the OT, SALT and staff members in developing daily living skills including making a cup of tea.

The residents engaged positively in the local community accessing, for example, various classes and the local hairdressers. Quite a lot of activities were being held in house, for example, quiz nights and yoga classes.

Judgment:

Substantially Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

The centre comprised a large period two storey house (main house) and accommodation in courtyard buildings located approximately 5km from a large town. Attractive, mature and well-maintained grounds surrounded the centre. The extensive grounds were freely accessible. There was adequate private and communal space for residents. Each resident had their own bedroom or apartment which was personalised with soft furnishings, photographs and personal effects. Ample storage space was provided for residents' personal use.

Accommodation for residents in the main house was provided on the ground floor only. Offices and staff facilities were located on the first floor. There were ten single en-suite bedrooms, eight studio apartments and four one-bedroom apartments on the ground floor. The apartments provided en-suite sanitary facilities and an area for preparing food. Communal areas in the main house included a sitting room, a pleasant oratory and a dining room. A designated smoking room was provided for residents. Accessible toilet facilities were located in close proximity to the communal areas. There was an adequate laundry area and residents were supported to launder their own clothes if they so wished. Inspectors saw that residents availed of the hydrotherapy pool and a physiotherapy room in the house.

The courtyard buildings were renovated in 2006 and comprised five one-bedroom apartments which each opened out into an attractive communal patio area. A large communal space which included a dining area was located beside the kitchen facilities. A bedroom was provided for sleepover staff.

Inspectors observed that the sitting room had been redecorated and residents had been consulted. Seating had been replaced with comfortable reclining chairs and sofa. The sitting room was homely and inviting. Activities such as board games and movie evenings were facilitated in the sitting room.

The centre was reasonably well-maintained internally and externally. A maintenance programme had been implemented which ensured that all areas requiring attention were remedied, repaired or replaced in a timely fashion. There was suitable heating, lighting and ventilation. Sufficient and appropriate furnishings, fixtures and fittings were provided. Arrangements were in place for the safe disposal of clinical and general waste. There was a separate kitchen area in both the main house and the courtyard with suitably equipped and with sufficient facilities.

Inspectors reviewed cleaning practices and spoke with housekeeping staff. A cleaning schedule was in place and housekeeping staff were aware of the schedule. The head of housekeeping and provisions regularly audited cleaning practices throughout the centre. Inspectors saw that the cleaning and decontamination schedule was implemented and cleaning standards were maintained.

A service contract was in place for beds, manual handling equipment, wheelchairs and other equipment in the centre. Records were maintained which demonstrated that bedrails were inspected monthly and were repaired or replaced where necessary.

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):

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

Findings:

There was a policy in place for risk management and health and safety. Satisfactory infection control measures were in place. Inspectors spoke with household staff members who demonstrated their knowledge of procedures in relation to the prevention of infection. Arrangements were in place for investigating and learning from serious incidents such as medication errors which were identified by the inspectors. These errors were identified, investigated and addressed with appropriate measures in place, such as staff not administering medication until receiving further training and supervision.

Some staff required training in moving and handling of residents. This is addressed

under outcome 17: Workforce. However, individual support plans were in place for residents in relation to safe manual and handling practices and staff were aware of individual resident's needs.

Risk assessments were in place for residents who availed of bed rails. There was also a risk assessment for a resident who was unable to use the call button; there was evidence that the resident was checked hourly during the night.

Records showed that the fire detection and alarm system was serviced at intervals varying between three and four months, but servicing did not always occur four times in a twelve month period. The centre had suitable fire equipment, alarms, emergency lighting and evacuation chairs. Inspectors found that the needs of residents in the event of a fire were assessed by way of a personal emergency egress plan (PEEP). On inspection, the residents' PEEPs were found to be detailed and addressed the methods of evacuation for both day and night time scenarios. According to the training matrix staff members were trained in what to do in the event of a fire. There was a comprehensive risk register in place and individual risk assessments were in place for residents.

In general, the inspector found that each building was laid out so that residents and staff were provided with an appropriate number of escape routes and fire exits. In the main house, bedrooms and apartments were provided with double doors leading directly to external grounds. Bedrooms and apartments were found to have either an electronic magnetic locking device or thumb-turn manual door opening fastenings. Throughout the centre, bed evacuation was facilitated which included moving beds to an assembly point. The external path outside two bedrooms was laid out so that the path widened at each exit to allow for beds to be moved out of the room and directed along the path.

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):
No actions were required from the previous inspection.

Findings:

There was a positive behaviour support policy in place in the centre and inspectors found that behaviour support plans reviewed demonstrated a positive approach to behaviour that may challenge, were appropriate and effective. The behaviour support plan included possible causes, triggers, warning signs, proactive strategies, reactive strategies and debriefing following an incident. However, not all staff had received training in relation to positive behaviour support. The training matrix made available to inspectors indicated that five staff required refresher training and four staff required initial training. This was confirmed with the management team.

The policy in relation to restrictive practices was made available to the inspector. The policy had been reviewed in April 2014, was comprehensive and was in line with evidence-based practice. A risk balance tool was used prior to the implementation of restraint, less restrictive alternatives were considered and signed consent from residents was secured where possible. Multidisciplinary input had been sought when planning and reviewing individual interventions for residents. There was a policy in place on the use of restrictive practices and physical, chemical and environmental restraint. Restrictive practices were monitored and reviewed regularly and resident's rights were protected. All alternative measures were considered before a restrictive procedure was implemented and family members were informed of the use of restrictive practices. For one resident, hourly checks were carried out to ensure they were offered opportunity for exercise or repositioning, some residents were asked regularly if they wished for their lap belt to be 'released', others had the ability to release their lap belt themselves.

There was a safeguarding and protection and welfare policy in place for the centre. Measures were in place to safeguard residents from abuse. Incidents, allegations or suspicions of abuse were recorded, appropriately investigated and responded to, in line with the centre's policy, national guidance and legislation. Staff and residents were aware of the safeguarding measures in place and how to report any concerns. However, gaps were identified in relation to safeguarding training for staff. The training matrix made available to inspectors indicated that 12 staff required refresher training and one staff required initial training. The management team outlined that training had been booked in early June but had to be cancelled at short notice.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

There was a policy on access to education, training and development. However, the policy did not outline the arrangements in place to support residents to access opportunities for education, training and employment or to support residents in transition between services.

Each resident's personal care plan included a 'quality of life' domain which outlined the residents' needs and supports in relation to new experiences, social participation, lifelong learning or education, training and employment. Some residents availed of a day service, work placement programmes or training courses external to the centre. Residents were supported to access opportunities for new experiences and social participation in the local community. Residents outlined to inspectors that they enjoyed attending local social groups, shopping in the local town or nearby cities, accessing postal and banking services locally, meals out, visiting the local library and going on holidays.

While an assessment to establish each resident's educational or lifelong learning, employment and training goals was not in place as yet, the person in charge produced and explained a draft document which she was implementing.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents were supported on an individual basis to achieve and enjoy best possible health. The significant improvements noted at the previous inspection in this area were seen to be sustained on this inspection.

Inspectors noted that a new sleep system was in place for a resident which outlined very clear visual information for staff. While the OT had made reference in emails, of the positive effects for the resident, evidence of the effectiveness of the sleep system was not regularly evaluated by staff; but staff were knowledgeable about the system.

Residents' healthcare needs were met through timely access to healthcare services and appropriate treatment and therapies. A general practitioner (GP) of their choice was

available to each resident and an out of hours doctor service was available if required. Access to a GP was facilitated regularly and access was timely when residents became unwell. There was clear evidence that their treatment was recommended and agreed by residents, this treatment was facilitated. Residents' right to refuse medical treatment was respected.

Where referrals were made to specialist services or consultants, staff supported residents to attend appointments. In line with their needs, residents had access to allied health professionals including OT, psychiatry, physiotherapy, SALT, dietician, optical and dental services. A system was in place to ensure that referrals were followed up and this was overseen by the clinical nurse manager.

Inspectors reviewed a sample of care plans relating to healthcare and saw that a robust system was in place for the development, implementation and review of care plans. Evidence-based tools were used to assess each resident's healthcare individual needs. The assessments informed the development of individual healthcare plans. Healthcare plans were developed in line with each resident's assessed needs and contained individualised information to guide staff to support residents. Healthcare plans were updated when residents' needs changed and reflected recommendations from members of the multidisciplinary team.

Where residents receive nutrition via enteral tube, adequate measures were in place to manage the risks associated. Appropriate and regular input was sought from the dietician and recommendations made by the dietician were incorporated into the resident's care plan. Inspectors observed that hourly safety checks were undertaken. The fluid intake and output chart clearly outlined the total volume of nutrition infused, rate of infusion, volume introduced during flushes and total fluid remaining. Nursing staff checked the fluid intake and output chart periodically throughout the day and calculated the total fluid intake and output daily. The daily management of the entry site was recorded, in line with the resident's individualised care plan.

Adequate storage facilities were provided to store food in hygienic conditions. Food served was sufficient in quantity, freshly prepared, nutritious and wholesome and was of a good standard. There was evidence that choice was available to residents for breakfast, lunch and evening tea with respect to menu options and dining location. The menu for the day was displayed on a whiteboard in the dining area of the main house and the courtyard. Inspectors observed that meal times were unhurried, positive and social events. Assistance was provided in a dignified and appropriate manner. Staff were aware of the recommendations from the dietician and SALT and these recommendations were seen to be implemented. Snacks and refreshments were observed to be available at all times. Kitchenette facilities were provided in many of the residents' bedrooms and residents were observed to be supported to prepare snacks and light meals.

Inspectors saw that systems were in place to ensure that care and support at end of life or times of illness was provided in a way that met the resident's individual physical, emotional, social and spiritual needs. A process was in place to sensitively capture and document each resident's wishes and these were seen to be respected. The resident's dignity, autonomy and rights were respected. Specialist services could be accessed through the local hospice and palliative homecare teams.

Residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. Health information specific to residents' needs was available in an easy-read format.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Each resident was protected by the centre's policies and procedures for medicines management. The significant improvements noted at the previous inspection in medicines management were seen to be sustained on this inspection.

A comprehensive medicines management policy was in place which detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines. Inspectors spoke with staff who demonstrated an understanding of medicines management and adherence to guidelines and regulatory requirements. Staff who administered medicines had received blended training in medicines which included a competency assessment.

Medicines and pharmaceutical services were provided by a local community pharmacy. The pharmacist was facilitated to meet the obligations under relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Residents were familiar with their pharmacist and were supported to access to pharmaceutical services.

Medicines were stored securely throughout. Medicines requiring refrigeration were stored securely and appropriately. Medicines requiring additional controls were stored and managed in line with legislative requirements, national guidance and the centre's policy.

A personalised medicines management plan had been developed for each resident which outlined the resident's prescribed medicines, frequency of review and the resident's preferences in relation to medicines administration. Staff identified residents who were managing their own medicines. Some residents managed all their medicines independently while other residents received some level of practical support to manage and administer medicines. A comprehensive and individualised assessment had been

completed for each resident. This information was incorporated into each resident's personalised medicines management plan.

A robust system was in place for the safe ordering and receipt of medicines. Medicines were delivered from the pharmacy and nursing staff checked the medicines delivered against the prescriptions. Any discrepancies or queries were immediately addressed with the pharmacy before medicines were used. Many medicines were dispensed in monitored dose systems and information was available to staff to identify each individual medicine.

Inspectors saw that medication related incidents were identified, reported on an incident form and there were arrangements in place for investigating incidents. Medication related incidents were analysed by the clinical nurse manager to identify trends and a number of measures had been implemented to prevent recurrence. Where trends were identified, the clinical nurse manager adopted a systemic approach to review and implementation of controls to prevent recurrence

A sample of medication prescription, administration records and monitored dose systems was reviewed. Medication administration records identified the medicines on the prescription and allowed space to record comments on withholding or refusing medications. It was demonstrated that medicines were administered as prescribed.

Staff outlined the manner in which medications which were expired or dispensed to a resident but were no longer needed are stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail. However, the date of opening was not recorded for eye drops that had a reduced expiry date when opened. Therefore, staff could not identify when the medicine would expire.

A system was in place for reviewing and monitoring safe medicines management practices. An audit of medicines management documentation was completed on a weekly basis by nursing staff. The audit was augmented by a comprehensive internal medicines management audit completed by the clinical nurse manager and an external audit completed by the pharmacist. The audits examined the aspects of the medicines management cycle including administration, documentation, storage and disposal of medicines. The audit identified pertinent deficiencies and actions were completed in a timely fashion.

Judgment:

Substantially 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):

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

Findings:

A comprehensive annual review of the quality and safety of care and support in the centre had been completed and was reviewed on this inspection. The service review examined areas such as staffing levels, service delivery, personal goals, community inclusion, complaints management, incidents and audit findings. Individual meetings were held with residents which informed the review. A robust action plan was developed from the annual review and demonstrated learning and continual improvement.

The person in charge had commenced in her role on 18 April 2016. The person in charge demonstrated that she had the appropriate qualifications, skills and experience to manage the designated centre. There was a clearly defined management structure which was outlined in the residents booklet.

Inspectors noted that residents had complex conditions and required significant clinical support. These complex conditions included multiple sclerosis, acquired brain injury, epilepsy, history of stroke, diabetes, visual impairment and muscular dystrophy. The residents required a number of clinical interventions on a daily basis including the management of catheters, enteral tubes, assistance with dining, pain management and complex medicines management. Since the previous inspection a CNM had started in Rathfredagh and oversaw the daily clinical management of the service to ensure resident safety. Positive clinical practices and governance were observed on this inspection in relation to the management of enteral nutrition and medication management.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

There was a planned and actual staff roster in place which showed the staff on duty during the day at night. Based on observations, a review of the roster and these inspection findings, inspectors was satisfied that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs of the residents. A regular team supported residents and this provided continuity of care and support. Since the most recent inspection, a number of night time shifts covering the periods from 22:00 to 08:00 were covered by nursing staff. For the night shifts where nursing staff were not on duty from 22:00 to 08:00, a formal on-call system for regular nursing staff was in place to support non-nursing staff overnight. The log of calls to the on-call system was reviewed by an inspector who noted that appropriate calls were made and a timely response was provided. Staff with whom inspectors spoke were familiar with the on-call system and reported that it was operating satisfactorily. The person in charge and regional manager outlined plans to extend nursing cover which will result in a nurse on duty at all times day and night.

A sample of staff files was reviewed and found to contain all the required elements. There was evidence of effective recruitment and induction procedures, in line with the centre's policy. Documentary evidence of up to date registration with the relevant professional body was provided where appropriate.

Robust procedures were in place for formal supervision of staff. Supervision took place at least four times per year. The supervision was of good quality and actions improved practice and accountability.

The person in charge outlined that rolling team meetings took place with nursing staff, support staff and the senior team on a monthly basis. Minutes made available to inspectors outlined that pertinent issues were discussed with each group. Inspectors saw that copies of both the Regulations and the standards had been made available to staff and staff spoken with demonstrated adequate knowledge of these documents.

Staff training records demonstrated a proactive commitment to the maintenance and development of staff knowledge and competencies the programme reflected the needs of residents. However, gaps in relevant training were noted relating to care for non-nursing staff who could potentially work at night without on-site nursing support. there were some deficits noted in provision of training for staff in first aid: eight staff members required initial training and five staff members required refresher training. In relation to training for dysphagia, the training matrix indicated that one recently recruited staff member required initial training and three staff members required refresher training. In addition, six staff members required refresher training in the area of safe moving and handling.

Volunteers received supervision and vetting appropriate to their role and level of involvement in the centre.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The training matrix did not reflect up-to-date and completed staff training. For example, the matrix identified that 19 staff members had not completed training in the management of enteral nutrition. It was confirmed by the community service coordinator that all staff had completed training in this area but the sign in sheet for one session had been misplaced. The community service coordinator and the clinical nurse manager outlined that measures would be put in place to ensure that staff who had attended this session were competent in this area and had signed that they had attended.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Cora McCarthy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority
Regulation Directorate**

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003449
Date of Inspection:	19 June 2017
Date of response:	24 July 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:

Improvement was required to ensure that all residents could make choices around meal options.

1. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the

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

freedom to exercise choice and control in his or her daily life.

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

The speech and language therapist has prepared and implemented a pictured menu plan with the chef for all residents that are non-verbal/ resident with communication challenges.

Proposed Timescale: 11/07/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Not all residents who were non-verbal were assessed or facilitated to communicate in an alternative manner through technology or visual aids.

2. Action Required:

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

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

The communication needs and ability of the resident in question were discussed as part of the monthly MDT meeting.

The Resident noted in the report has been provided (beyond the already existing communication passport) with a communication flipbook that she can carry with her. This utilizes pictograms (AAC method) for daily activities. A daily activity board with pictures has been added to residents' room and her "Who am I" document has been modified into accessible format for her to use.

Menu is available in kitchen in AAC format and the physiotherapist is using pictures to support the oral communication when offering different exercises/ selection of exercises.

Alternative communication methods will be made available to any future residents with communication challenges or cognitive impairments.

Proposed Timescale: 14/07/2017

Outcome 05: Social Care Needs

Theme: Effective Services

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

the following respect:

A comprehensive assessment of one resident's communication needs was not evidenced.

3. 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:

The communication needs of the resident in question were discussed as part of the monthly MDT meeting in July 2017 after the inspection. It was noted that there is a SALT assessment done for all the residents, but in this particular case it could be more conclusive.

SALT has carried out an appropriate overall functional assessment on communication needs and methods of the resident in question.

For any future residents with communication challenges an overall communication assessment will be carried out specifying any necessary additional AAC methods.

Proposed Timescale: 20/07/2017

Theme: Effective Services

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

Some goals outlined in residents' personal plans were task orientated, for example, a hairdresser appointment, and not outcome-focused goals.

4. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

All personal plans to be reviewed and 3-5 active outcome oriented goals minimum to be identified on different life areas for each resident. A clearly outlined time schedule for the outcomes to be assessed will be set.

Proposed Timescale: 30/08/2017

Theme: Effective Services

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

Information was not readily available to residents and staff.

5. Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

Residents "Who am I" – documents have been made available for the residents to use in appropriate format where suitable or should they wish to use them.

Proposed Timescale: 11/07/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Not all staff had received training in relation to positive behaviour support.

6. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

All remaining staff will be trained by 14th of August 2017, an annual training schedule will be organised on rotating basis so that all staff training can be kept up to date going forward.

Proposed Timescale: 14/08/2017

Theme: Safe Services

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

Gaps were identified in relation to safeguarding training for staff.

7. Action Required:

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

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

All outstanding staff will be trained by 10th of August 2017, an annual training schedule will be organised on rotating basis so that all staff training can be kept up to date going forward.

Proposed Timescale: 10/08/2017

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:

A robust and objective assessment to establish each resident's educational or life long learning, employment and training goals was not evidenced.

The policy on access to education, training and development did not outline the arrangements in place to support residents to access opportunities for education, training and employment or to support residents in transition between services.

8. Action Required:

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

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

Each resident will have a future planning profile document. Within this document, residents will be supported to identify and express desired educational or lifelong learning, employment and training goals with their key workers. This will be written together with the resident and where appropriate will include information from MDT and annual service reviews with management.

Assigned keyworkers will be trained in Future profile planning on 14th and 21st of August 2017.

Time schedule has been established and all future planning tools for residents in the service will be finalized in the following sequence:

- By end of August 2017 first half of residents assessed and future planning profile ready
- By end of September 2017 second half of residents assessed and future planning profile ready.

The policy will be reviewed and approved by 01/10/2017. The revised policy will reference the support to be given to residents in the identification of their desired educational, lifelong learning, employment and training goals (through use of the individual's Future Planning process), and will outline the supports Cheshire Ireland will provide to residents to assist them achieve their expressed goals. The policy will also outline the steps to be taken to ensure that a resident may continue to participate in their educational, lifelong learning, employment and training goals should they be transitioning between services.

Proposed Timescale: 01/10/2017

Outcome 12. Medication Management

Theme: Health and Development

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

The date of opening was not recorded for eye drops that had a reduced expiry date when opened.

9. Action Required:

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

Issue with eye drops has been rectified on the day of the inspection.

All staff has been advised on standard medication management procedure concerning products that have expired after opening in certain time period. Same will be officially recorded in team meeting. Robust medication auditing system will be continued to spot any future errors in daily medication management.

Proposed Timescale: 12/07/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

A number of staff required initial or refresher training in the areas of first aid, dysphagia and safe moving and handling.

10. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

All staff will be trained in first aid, dysphagia, and safe moving and handling by 30-08-2017, an annual training schedule will be organised on rotating basis so that all staff training can be kept up to date going forward.

Proposed Timescale: 30/08/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

Training records were not complete.

11. Action Required:

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:

Extra training conducted due to the training record gone missing, all staff in question re-trained 18-07-2017. All staff is now PEG trained up to date.

Proposed Timescale: 18/07/2017