

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003447
Centre county:	Kerry
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Mary O'Mahony
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
09 December 2014 10:00	09 December 2014 17:30
10 December 2014 09:30	10 December 2014 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

The Health Information and Quality Authority's second inspection of this centre was announced. As part of the inspection the inspector met with residents, the person in charge, the service quality officer (SQO) who was deputising for the provider, relatives and care assistants. The inspector spoke with the person in charge and discussed the management and governance arrangements for supporting staff and residents. The inspector reviewed the policies and procedures in the centre and examined documentation which covered issues such as medication management, complaints, incidents, personal plans, staff files, fire safety records and training records.

The person in charge informed the inspector that she endeavoured to provide a person-centred service to effectively meet the needs of residents. On the day of inspection there were twelve residents in the centre. While the inspection was in progress the residents were seen to attend various day care centres and to be entertaining visitors.

The centre was located in a quiet cul-de-sac near a large town. While the centre was housed in one large single-storey building it was divided into twelve self-contained apartments. These were accessible from an individual front or back door as well as from the central communal area within. Residents and their representatives were involved in maintaining their own garden area outside each apartment. These were well maintained and contained with shrubs, ornaments and bird tables. There were adequate parking spaces around the building and some of the residents had specially adapted cars. These could be driven by family members or personal assistants. The inspector noted that there was a minibus parked in the car park which was available for use by all the residents. This was seen to be in use during the day when residents were coming back from their daily outing.

The action plan at the end of the report identifies areas where improvements were needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities. The centre was served with an immediate action plan as regards the governance and management arrangements for the centre and a satisfactory response was received to this within the designated time frame. The initial action plan received by the Authority was not acceptable and a second more satisfactory action plan was received within the designated timeframe.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

The inspector noted that the rights of residents were supported by staff in the centre. There was a regular consultation process in place which the person in charge said was adapted to the residents' needs. Minutes of a recent residents' meeting dated 12 Nov 2014 were viewed by the inspector. The person in charge explained how residents accessed advocacy services and staff spoke with the inspector about the importance of advocacy for residents. The named advocate's contact details were displayed on a notice board in the hallway with accompanying information on the advocacy service. The person in charge informed the inspector that regular meetings with individual residents also took place and any concerns or complaints were recorded and investigated. Records to support this were viewed by the inspector. Residents with whom the inspector spoke confirmed that meetings took place. The previous HIQA inspection report had been read to the residents and their comments had been documented.

A folder containing accessible documents was visibly displayed on the hall table. This included information on how to make a complaint, residents' rights, access to advocacy, the resident's guide and the statement of purpose. There was pictorial input in the documents also. A relative with whom the inspector spoke said that residents and their representatives were involved in formulating personal plans. Residents could make choices about their daily lives with support from staff and staff with whom the inspector spoke were aware of the residents' likes and dislikes. The staff roster was available for viewing by the inspector and this indicated continuity of staff in the centre. The provider had developed policies to guide staff on the care of residents' property and money management as required by Regulations. The person in charge informed the inspector that personal belongings were listed and signed by the resident. Consent forms were signed for medication administration, photographs where required and financial

transactions. This documentation was reviewed by the inspector.

There was access for residents to local amenities such as the local park, library, shops, restaurants and hairdressing facilities. Residents were facilitated to go for walks or drives and to take part in arts and crafts, multi-sensory sessions, garden activities and swimming among other interests. Day trips and overnight outings, which were in line with their individual assessed needs, were arranged. Family members informed the inspector that they had been consulted, where appropriate, in this planning and that the person in charge was responsive to them. Residents had access to personal transport that was driven by staff who had attended an appropriate driving course. However, staff shortages impeded all residents from attending various events in which they had expressed an interest and this also impacted on achieving some of their goals. Residents spoke about this with the inspector and this issue was addressed under outcome 17: Workforce. Residents were supported to attend religious ceremonies of their choice. At the time of inspection staff were planning the annual Christmas Mass to which friends and family had been invited. The centre received support from Enable Ireland: the Irish Wheelchair Association: the local public health nurse team: the Health Service Executive (HSE): Headway: Cuislan and Cheshire Adventure Motivation Programme (CAMP) among others in the community.

There was a complaints policy in operation in the centre. However, the policy was last reviewed in 2009. This issue will be addressed under outcome 18: Records and Documentation. Nevertheless, the new draft policy was seen by the inspector. An easy-to-read version of the complaints procedure for residents and their representatives was prominently located in the entrance hall. The centre had a dedicated complaints officer and an independent nominated person. Staff and residents with whom the inspector spoke were aware of the names of these personnel and how to initiate a complaint. The inspector spoke with a relative who was familiar with this procedure. The deputy provider informed the inspector that there was both a regional and national response to complaints and said that the complaints were audited to help identify where training was required. The inspector observed that there were complaint forms freely available in the entrance hallway. The inspector noted a pattern of complaints about named staff members and it was noted that these had been forwarded to the Authority. The inspector discussed on-going management of these issues with the person in charge and the S.Q.O.

The centre had 12 apartments and each had a bedroom, kitchen and an en suite facility. These were wheelchair accessible. There were large wardrobes, shelving and locked storage facilities available for each resident.

Judgment:
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:

The inspector found that staff were aware of the communication needs of residents and the care plans seen by the inspector indicated that communication needs were being met with support from the advocacy, social work and speech and language therapy (SALT) services. The residents' representatives were consulted in the formulation of plans where appropriate. Plans of care outlined specific means of communication and were seen to be detailed, including information such as how residents expressed different emotions through their behaviour. The inspector reviewed care plans outlining how to communicate with non verbal residents. There was evidence that multi-disciplinary professional input was sought where required. For example from psychologists, psychiatrists and the general practitioner (GP). There were televisions, DVD players and radios available to residents. Residents had their own phones and the use of mobile phones was encouraged with broadband access available on the premises. Some residents had kindles (for access to books online) and i-pads on which they could use Skype for contacting their relatives.

The behaviour specialist provided advice and detailed steps to be followed when providing positive behaviour support. The inspector saw that this information was included in the personal plans of any resident who required this expertise and for the attention of all staff. Friends and relatives were encouraged to visit the centre and each resident had a small sitting room available for private visits. The inspector met with a relative who confirmed that staff were always welcoming and inclusive. Staff informed the inspector about relevant care issues and details of residents' care plans which indicated to the inspector that a person centred approach was fostered in the centre.

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:

The inspector found that fostering positive relationships between residents and their representatives formed part of the ethos of the centre. A representative of a resident living in the centre confirmed this with the inspector. Contacts and social links were supported by a variety of means. There was an open door visiting policy and family, relatives and friends were welcome to visit. Contact was supported as appropriate to

each resident, for example the person in charge informed the inspector that home visits, phone contact and special occasions were facilitated by the centre. Family or residents' representatives were encouraged to attend birthdays and other special occasions such as Christmas parties. Staff said that they would facilitate residents' representatives who wished to take an individual resident out for shopping, for a meal or to celebrate a special event. A relative's representative outlined to the inspector how supportive and friendly the staff were and how she felt her relative was safe and happy in the centre. There was evidence of personal links in the personal plans seen. Residents' representatives were contacted by the person in charge in advance of the review of a resident's personal plan and invited to attend the review meeting. Input from relevant people, in relation to individual resident's wishes and preferences, was documented in the personal plans seen by the inspector.

Residents with whom the inspector spoke informed the inspector that relatives could stay overnight with them if they wished. There was evidence of community support and links were forged with individuals and organisations who had a long standing loyalty to the service, according to the person in charge. For example one resident told the inspector that she had recently held an art exhibition which was hosted in a local business premises and that this had been well supported by local people.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

The inspector found that the process of admissions was in line with details in the statement of purpose. Contracts of care set out the service to be provided in the designated centre. Contracts of care were signed by the person in charge and next of kin, where appropriate. However, the fees for the service were not outlined on the contracts of care seen by the inspector. This was required by the Regulations.

If the need arose a member of staff would meet with residents and their families or representatives and review current living arrangements and any wishes in relation to transition between services. There was evidence that moves were planned in an organised and person-centred way. Transfers and admissions were overseen by senior staff and information meetings were held. Consultation with residents was undertaken in line with their abilities and input was sought from their representatives and the multi-disciplinary team. The inspector spoke with the person in charge, staff and relatives who confirmed that these arrangements were in place. There was a transfer, admission and

discharge policy in place in the centre. The person in charge informed the inspector that residents rarely ask to transition to another service as she felt that their independence and autonomy was respected and encouraged.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Each residents' wellbeing and welfare was maintained by a high standard of evidenced based care and support. They were facilitated to maintain maximum independence and to participate in meaningful appropriate events. The inspector was informed by residents and staff that there were a number of options available to them in relation to activities and work. The inspector noted that residents were fully involved in their own daily routine which included cooking, laundry and shopping where possible. The inspector spoke with residents throughout the inspection and they outlined their overall positive experience of living in the centre.

Residents spoke with the inspector about a number of off-site activities they enjoyed including shopping, home visits, men's shed, life skills training, restaurant outings, concerts at a nearby national venue, holidays, art, and attending workshops. Other residents spoke with the inspector about how they enjoyed relaxing at the end of the day; sometimes cooking their evening meal or watching television and listening to music. The inspector saw letters in each resident's file informing them about the inspection and the person in charge had spoken with them about the process involved. As a result of this preparation the inspector noted that the residents had a very positive outlook and they were waiting to meet and talk with the inspector.

There was a good supply of board games, CDs, books and DVDs on offer in the communal sitting room and in the residents' own apartments. These were seen to be personalised with furniture, pictures and photographs. Residents showed the inspector their personal selection of CD's and DVD's as well as their music centres and televisions. The bedrooms were furnished with good quality furniture and residents could receive visitors through their own front door, adding to their sense of independence.

The person in charge showed the inspector the personal plans for each individual and it was evident that the residents had been consulted in relation to the content of this documentation. Residents were able to access their personal plans at any time. The inspector viewed evidence that residents had access to allied health services such as the dietician, physiotherapist, occupational therapist, dentist and the general practitioner. They were supported in their physical care by the healthcare assistants while the personal assistants supported them in their social interactions. The person in charge told the inspector that the centre received weekly input from the local public health nurse and the local HSE services. She acknowledged that this was a great advantage for residents. Each resident had a 'portable medical profile plan' prepared in their file. Personal plans were seen to be implemented and the inspector heard from residents how there was individual recognition and support for their personal goals. There was evidence that the personal plans were reviewed regularly.

Some residents had completed an advanced wishes end-of life care plan and this was reviewed on a regular basis. There was an emphasis on promoting autonomy and some residents stayed out in a family member's home at weekends or for holidays.

Judgment:

Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The inspector found that the centre was designed and laid out in a way that was suitable for its stated purpose. It was newly painted and the furniture and fittings were of a high standard. The inspector noted that the centre was clean, comfortable and homely. The apartments and communal rooms were bright and spacious. Corridors and doorways were wide and the centre was fully accessible to residents. There was a wheelchair ramp outside the front door and each resident also had their own individual apartment front door. Facilities and services were consistent with those described in the centre's statement of purpose and resident's guide.

There were sufficient communal and private areas available for residents' use and there was a large sitting room, conservatory and well equipped communal kitchen in the centre. Each resident had a private, bedroom, en suite, kitchen and sitting room. There were suitable arrangements available for the disposal of general waste and the person in charge informed the inspector the community public health nurse would provide support in the disposal of 'sharps' and clinical waste. However, areas where hazards

were present were not all restricted for example, storage rooms, electricity panels and chemical cupboards. The inspector observed that there were risk assessments carried out for most of the hazards identified in the centre and controls had been put in place for these. Hazards which had not been identified will be listed under outcome 7: Health and Safety and Risk Management. There were sufficient toilets, bathrooms and showers to meet the needs of residents. However, the inspector noted that there were some repairs needed on the ceiling outside one apartment and the woodwork in the centre required repainting.

Judgment:

Non Compliant - Minor

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:

The centre had a health and safety statement and it was relevant to the centre. There was a health and safety committee which met on a monthly basis and the inspector read the minutes of these meetings. There was a monthly audit of health and safety issues in the centre and the centre had the services of a health and safety officer.

Procedures were in place for the prevention and control of infection. Alcohol hand gels and disposable gloves were available. However, alginate bags were not available for the segregation of laundry in the event of an outbreak of infection. Housekeeping and laundry duties were carried out by the cleaning staff and staff in the centre and the laundry was well equipped for the needs of the centre. The inspector also observed a resident attending to her own laundry needs. The centre had the services of an infection control nurse in the region.

The centre had a risk management policy and a risk register which captured some potential risks (environmental, operational and clinical) associated with the centre. There were some measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents, such as the monthly health and safety meeting. The staff informed the inspector that incidents and adverse events were also discussed at staff meetings. The inspectors viewed minutes of these meetings.

However, all risks in the centre had not been identified and assessed and the risk register did not contain the controls in place to eliminate or minimise these risks. These included the low placement of the electricity panel on each apartment, the storage of vinyl gloves, open presses containing chemicals, infection control procedures for washing kitchen and bathroom floors within the apartments.

The inspector noted that incidents in the adverse incident book were recorded in detail and that the process of learning from these events was more robust than on the previous inspection. The inspector noted however that some incidents continued to occur and staff training and supervision was discussed with the person in charge. In view of the nature of the recurring incidents the inspector spoke with the person in charge about the provision of training in effectively managing and de-escalating 'behaviour that challenges'. However, records seen by the inspector confirmed that training in positive behaviour support and in behaviours that challenge had not been made available for all staff since the last inspection. Staff spoken with by the inspector confirmed that "it was a while" since they had attending this training, which is mandatory. One staff member said she had yet to do this training and some staff members' training was out of date. This will be addressed under outcome 8: Safeguarding and safety. A member of the cleaning staff had not been afforded infection control training relevant to her role. This will be addressed under outcome 17: Workforce.

An emergency plan was in place and a safe placement for residents in the event of an evacuation had been identified. Regular fire drill training was documented and there were personal evacuation plans for residents. Records reviewed by the inspector indicated that the fire alarm was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. The fire assembly points were identified and there was appropriate emergency lighting in place. There was evidence that arrangements were in place for daily checking of fire precautions which included the alarm panel, the fire exits, and the testing of fire equipment. The inspector noted that fire exits were unobstructed. Staff spoken with by the inspector were aware of what to do in the event of a fire. The procedure was also displayed in both hallways to increase awareness. Residents had individual fire evacuation and emergency plans (PEEPS) on display in their bedrooms. However, a staff member spoken with by the inspector was not aware of the location of these plans.

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):

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

Findings:

The person in charge informed the inspector that she was actively involved in the management of the centre. She said she was confident of the safety of residents through speaking with residents and their family members and observing the interactions between residents and between staff and residents. Residents said they felt safe in the centre and this was attributed to the fact that they were familiar with the staff and their personal assistants (P.A.). The inspector saw evidence that the staff and residents were very comfortable in each other's company. However, similar to the last inspection, from a review of events which were documented in the adverse incident book and from conversations with residents, it was obvious to the inspector that some staff required training in communication skills. Furthermore, all staff required training in positive behaviour support and behaviour which challenges, to support them in caring for residents with a high dependency. There was a policy on the management of allegations of abuse. Training records indicated that the staff had received training on the prevention and detection of abuse. However, not all staff members had received updated training. There was a policy on the prevention use of restrictive interventions which outlined measures to promote a restraint free environment.

There were measures in place for the management of some of the residents' finances. Most residents managed their finances independently and receipts were kept from shopping events and outings.

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):

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

Findings:

A detailed record of all incidents and adverse events was maintained in the centre. Since the previous inspection incidents which were recorded in the adverse incident book had been notified to the Authority in the appropriate manner and investigated appropriately.

Judgment:

Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents' opportunities for new experiences, social participation, training and employment were generally supported. Continuity of staffing, of activities and of educational opportunities was maintained for residents. An assessment of each resident's goals relevant to their general welfare and development was completed as part of a more comprehensive assessment of their needs, wishes and abilities. Goals were developed in accordance with their preferences and to maximise their independence. This was evident in the personal plans reviewed by the inspector. A number of off-site activities, such as art, music events, life skills training, swimming and crafts were made available. However, there was evidence that staff shortages impacted on residents attending all the events they wished. This was relayed to the inspector and discussed with the person in charge. Some residents informed the inspector that staff were too busy to socialise with the residents at times and that they would like more communal events. This issue will be addressed under outcome 17: Workforce.

One resident was in negotiations for extra personal support from a local organisation and she explained to the inspector how she was hoping that this would improve her quality of life. Staff informed the inspector that residents would be facilitated to shop for their meals and to choose what they wanted to cook on a daily basis. Educational and sporting achievements of residents were valued and pro-actively supported in the centre. The person in charge told the inspector that residents and staff engaged in planning new goals and accessing new educational opportunities on an annual basis. Some residents said however, that not all their goals are achieved. Staff were noted to be aware of the residents goals, when spoken with by the inspector.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents had access to general practitioner (GP) services and appropriate therapies, such as dentist, psychologist, dietician, occupational therapist, psychiatrist and speech and language therapist. In most situations residents were enabled to independently visit their GP. There was evidence that residents had availed of allied health care services and specialist consultants. Residents could avail of the services of a local dentist. Residents had been assessed by the dietician and the inspector observed that care plans

had been developed to support residents with diabetes and coeliac disease. The speech and language therapist had provided guidelines for safe swallowing for a resident with dysphagia (swallowing difficulties) and the occupational therapist had documented recommendations for suitable chairs and assistive devices. Regular multidisciplinary input was evident in the residents' personal plans.

The inspector saw signed agreements which the residents had drawn up for various aspects of their care. Some residents had documented their advanced care wishes. The inspector was informed by the person in charge that these were revisited at the yearly review meetings. The residents confirmed to the inspector that they were central to the care planning process. The inspector spoke with most residents in the centre throughout the day and they provided an in-depth picture of life in the centre and how their needs were attended to.

The inspector also spoke with relatives during the day and they were praiseworthy of staff and of the freedom to visit and decorate the apartments in a homely way according to residents' wishes. However, the visitors and residents both expressed that they felt that more staff were necessary as the needs of the residents had changed over time. This comment was also repeated in the pre-inspection questionnaires reviewed by the inspector. This issue will be addressed under outcome 16: Resources.

The inspector noted that residents had access to refreshments and snacks with a selection of fresh fruit and home baked bread. Residents, spoken with by the inspector, indicated that their individual likes and dislikes were taken into account when shopping and that they were encouraged to buy fruit and vegetables. Staff told the inspector that they would accompany residents on shopping trips. Some residents were capable of shopping independently using their mobility wheelchairs. Other residents had the support of a personal assistant (PA) for some hours during the week. Residents informed the inspector that this support was invaluable to them but that the time they were allocated was short. Residents explained how their various disabilities meant that each activity took longer than for an able-bodied person.

The inspector observed that the ethos of the centre encouraged and enabled residents to make healthy living choices in relation to exercise, weight control and dietary considerations. This was supported by information in the personal plans viewed by the inspector. Staff with whom the inspector spoke were knowledgeable about residents' health and social care needs and were observed to provide care as outlined in the personal plans. The person in charge and the staff members spoken with by the inspector, gave relevant information about each resident's medical and social needs. It was evident to the inspector from talking to staff and residents that they were afforded opportunities to participate in activities, which included concerts, watching television and DVDs, cooking, holidays, support groups, art, regular outings, music and shopping. As discussed previously these opportunities were dependent on staff or PA availability. This was addressed under outcome 17: Workforce.

The privacy, dignity and confidentiality of residents were safeguarded as information and documentation, relating to residents, was stored in the staff office. The residents were able to access their individualised personal plans and understood that their personal information and their confidentiality would be respected by the Authority.

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

Findings:
The medication management policy was up to date. Residents were supported to attend the pharmacy and there was evidence that residents' medications were reviewed regularly.

There was training for staff in medication administration however, the inspector spoke to the person in charge who said that a recent clinical audit had exposed medication errors, which were now being recorded. They had not been reported as errors by staff members but had been uncovered in audit and then recorded. The inspector observed medication errors in the sample of files viewed. The inspector noted that the wrong dose of one significant medication had been administered to a resident and this had gone unnoticed. The person in charge reported this to the resident's GP during the inspection and recorded the error. Medication errors were recorded in the adverse incident book but this record indicated that similar errors were being repeated. The inspector found that the system of audit was not robust. There was no record of the learning which occurred as the result of these errors. The person in charge informed the inspector that a review of training needs was being undertaken following her audit. There was no nurse in the centre. The person in charge informed the inspector that the centre was well supported by the local public health nurses who attended three times a week to administer various medical treatments as well as do any blood tests required.

Residents had been assessed for the ability to self-administer their medications and the person in charge said that some of the residents were assessed as suitable to self-administer. These assessments were available in the personal plans. However, there was no prescription in place in the file of one resident who was self administering medication. Unused or out of date medication was segregated for return to pharmacy as required.

The centre had controlled drugs in use. Since the last inspection there a was bound register for the recording of these drugs and there was a record kept of the drug count at the changeover of each shift. One of the public health nurses from the locality attended to administer any controlled drugs. The key of the controlled drug cupboard was kept safely. However, the inspector noted that there were two controlled drugs

recording omissions in the medication administration record (MAR) which had not been identified as errors or recorded as such. This was brought to the attention of the person in charge.

Since the last inspection staff in the centre were no longer transcribing medication. Two nursing staff attended from the organisation to transcribe drugs when required. These signatures were seen by the inspection on the transcription sheet. The maximum dose in 24 hours for PRN (when necessary) medication was stated for medications and there was a system in place to record the effect of administering PRN medications to a resident. The crushing of some medication was prescribed by the GP as required.

Staff training records on medication management were reviewed. The person in charge informed the inspector that four staff members had yet to undertake training. Staff members who were administering medication informed the inspector that following the training session a nurse supervised them before they could then administer medication. Not all these staff had their supervision sessions completed and the absence of a suitably qualified person to supervise these sessions was discussed with the person in charge. She informed the inspector that the centre was currently recruiting a suitable person.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose consisted of a statement of the aims of the centre and a statement as to the facilities and services which were to be provided for residents. The statement of purpose contained most of the information required by Schedule 1 of the Regulations, including the staffing complement and the organisation structure. It outlined the apartment sizes and the procedure for dealing with complaints which correlated with the notice on display in the centre. The statement of purpose was kept under review. It was last reviewed in December 2014 and was available to residents and their representatives in an accessible format. The inspector noted that the person in charge was ensuring that staff were familiar with the statement of purpose by encouraging them to read the updated version.

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):

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

Findings:

There was a governance and management structure in place which was in accordance with the structure outlined in the statement of purpose. The person in charge told the inspector that her post was full time and she was engaged in the governance, operational management and administration of the centre on a consistent basis. At the time of the previous inspection she had the support of a part time nurse in the centre and the area manager who attend the centre on a regular basis. However, this personnel were no longer available in the centre and the inspector noted that the person in charge did not have a designated suitably qualified person to deputise in her absence. Management meetings were mainly held by phone and the person in charge said she had good support from the provider and chief executive officer (CEO) of the organisation. The person in charge informed the inspector that she carried the on-call phone home with her at weekends. This lack of suitable management support and staff supervision was inadequate. The person in charge and the service quality officer of the organisation were issued with an immediate action plan as regards putting suitable personnel in place to support the person in charge and to provide staff supervision when the person in charge was not on duty. This was all the more relevant as responses in the pre-inspection questionnaire had indicated that care was seen to be better when the manager was on duty. A satisfactory response to the action plan was received within the time frame set out by the Authority.

Staff informed the inspector that they were facilitated to discuss issues of safety and quality of care at handover meetings which the person in charge facilitated. The staff had probationary supervisory meetings and appraisal meetings were in progress. There was a regular review of the quality and safety of care in the centre and audit of areas such as infection control and health and safety and medication management were taking place. As discussed previously there was a shortage of staff highlighted to the inspector. It was pointed out to the inspector by staff and residents that their needs had changed and residents had become more dependent. For example one resident who had dysphagia (swallowing difficulties) could need 40 minutes of staff support with his meals. Another resident had similar needs which required that a staff member sit outside his room door even if he was being supported by his relatives to eat his meals. This meant that there were only two members of staff available to cook all the meals individually in the apartments of the other 11 residents, as well as attend to other care

needs at that time. This was most relevant on Friday, Saturday and Sunday when all residents were present in the centre.

The person in charge was found to be experienced and demonstrated good leadership and organisational skills. The inspector spoke with the person in charge about her previous experience and her qualifications and commitment to the residents. Staff and residents were able to identify her as being the manager and staff told the inspector that she was supportive and approachable. She demonstrated sufficient knowledge of the legislation and her statutory obligations. She was able to demonstrate to the inspector that she was committed to her professional development. The inspector noted that all the documents requested were easily accessible in the centre and there were detailed files available in line with the requirements of the Regulations. However, the inspector noted that the person in charge lacked support in the management structure to enable her to delegate tasks to management colleagues.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The CEO of the service had been identified to deputise in the absence of the person in charge. However, this was discussed with the person in charge who agreed that the arrangement was not feasible due to the distance to be travelled. New arrangements were put in place following the issuing of an immediate action plan.

The provider was aware of his responsibility to inform the Authority of the absence of the person in charge in line with the requirements of the legislation and to notify the Authority of the arrangements in place for the absence.

The absence of the previous deputy had been notified to the Authority.

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 person in charge informed the inspector that a regular review of resources in the designated centre took place in consultation with the provider. The inspector spoke with the person in charge and staff members who confirmed that they had been provided with most of the required and mandatory training for their role. Some training had not been provided and this will be addressed under outcome 17: Workforce.

Resources had been provided to renovate, deep clean and prepare the centre for registration. The inspector found that the facilities and services available in the designated centre reflected what was outlined in the statement of purpose. However, as discussed in previous outcomes the inspector found that there were times during the day and at certain times of the week that staffing levels were not adequate to ensure the effective delivery of care and support in accordance with the statement of purpose. Entries in the complaints log supported this as a number of complaints involved residents waiting a long time for help and some staff being rushed and appearing brusque when attending to residents.

The person in charge confirmed that there was a household budget available to meet the day-to-day running costs of the centre, that residents were responsible for their own apartments and that any extra requirements would be met by management.

Judgment:

Non Compliant - Major

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:

A sample of staff files reviewed by the inspector generally complied with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013. However, in the sample of staff files viewed there were some required documents not available. For example, two staff members had only one reference available and not

all gaps in employment were accounted for. The inspector viewed the policies on staff recruitment and saw that staff had fulfilled the required vetting procedures and had the required references. There was robust induction process in the centre and the person in charge explained that this had recently been augmented. It was a module based programme.

Records reviewed indicated that staff had attended a range of training but this did not include all the mandatory training required by the Regulations, for example training on de-escalation techniques and supporting residents with behaviour which challenges. This training had last been delivered in 2011 to 13 staff members. One staff member spoken with by the inspector, had not received training in the recognition and response to adult abuse. Not all staff had received medication management training and had not completed their supervision sessions for this training. Staff supervision was not consistent. Not all staff had supervision or appraisal records available in their files.

There were two staff members on duty in the centre after ten at night and the person in charge was satisfied that all risks had been assessed for night time needs. The daily care notes viewed by the inspector indicated that the night staff were responsive if required to any issues which occurred on their shift.

The inspector viewed the planned roster for the following week. The inspector found that staff had a good understanding of their role and of the needs of the residents. Staff were able to demonstrate an awareness of the centre's policies and had access to a copy of the Regulations and the National Standards for the sector. The residents were familiar with the staff on duty on the day of inspection, which indicated to the inspector that there was continuity of care for the residents. The staff were familiar with the routine and the expectations of each resident however during the inspection residents informed the inspector that they would like if staff had more time to spend with them outside of the care aspects. Staff confirmed with the inspector that they felt rushed and that meals times were especially busy when all the residents were present 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):

No actions were required from the previous inspection.

Findings:

The inspector found that the number, qualifications and skill mix of staff was inappropriate to the number and assessed needs of residents. The staff rota was properly maintained. Staff informed the inspector that they were required to complete household duties as well as care duties when the household member of staff was not on duty. The person in charge and the service quality officer indicated to the inspector a commitment to providing ongoing supervision, education and training to staff relevant to their roles and responsibilities. The inspector spoke with staff who confirmed the training they had received and records of training were reviewed. The inspector reviewed a sample of staff training records and found however, that not all mandatory training required by the Regulations had been provided. Staff had completed other training or instruction relevant to their roles and responsibilities including courses in relation to hand hygiene, food hygiene, fire training, manual handling, first aid and dysphagia. The staff were supported by services from the Health Services Executive (HSE) and the local public health nurse service.

The centre had policies in place to conform with the Regulations however, not all policies were reviewed on at least a three yearly basis as required. An example of this was the policy on complaints management (2009). As discussed in outcome eight: Medication management, medication errors were not all recorded and all staff had not signed for the administration of medications.

Judgment:

Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary O'Mahony
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-0003447
Date of Inspection:	09 December 2014
Date of response:	18 February 2015

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 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:

The fees for the service were not outlined in the residents' contacts checked by the inspector.

Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the

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

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:

A) The service agreement currently in use has been amended to include a section regarding the fees charged within the service and discussed with each resident.

B) A review of the current service agreement is to be commenced by the Service Quality team.

A) Proposed Timescale: 28/02/2015. Responsible Individual(s): Service Manager

B) Proposed Timescale: 30/06/2015 Responsible Individual(s): Service Quality Team

Proposed Timescale: 30/06/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The woodwork on the apartment doors and skirting areas required repair.

An area of the ceiling outside apartment A required repair.

Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

Quotes have been requested for all the necessary maintenance work and funding has been ring-fenced to ensure this work is completed

Responsible Individual(s): Regional Manager & Service Manager

Proposed Timescale: 30/04/2015

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:

Not all the risks in the centre had been assessed, managed or reviewed.

For example:

-There were open cupboards containing cleaning chemicals and household detergents:

-There was an unlocked storage area where equipment and paint tins were stored:

-There was only one mop in use within the apartments for both kitchen and bathroom:

-There were no alginate bags available:

-Gloves were not stored safely:

-Electricity control panels which were placed at wheelchair accessible height were uncovered:

-Not all staff were aware of the location of the fire safety plans for residents

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:

- The Service Manager will communicate and work with the service users to allocate a locked cupboard in their apartment.
- Unlocked Storage Area : this issue has been resolved as the door to this area now is locked.
- Availability of cleaning equipment in apartments – new and sufficient quantities of cleaning equipment have been ordered.
- Alginate Bags have been ordered for the service.
- Gloves storage : The Service Manager is currently researching and sourcing an appropriate product for gloves storage within the apartments.
- Electricity Control Panel : The Service Manager has requested quotations from relevant professionals for the replacement of control panel boxes for all apartments.
- Staff Awareness regarding Fire Safety Plans : A memo regarding the location of the Personal Emergency Egress Plans for all service users has been communicated to all staff.
- An ongoing programme for the assessment, management and review of risk is in place within the service. The frequency for the review of identified risks within this service is 6 months and the overall management of risk is carried out in accordance with Cheshire Ireland’s Risk Management Policy.
- A system is in place for responding to emergencies within Kerry Cheshire and this will be communicated to all staff (at the next staff meeting) and service users (at the next service user meeting).

Responsible Individual(s): Service Manager, Cheshire Ireland’s National Risk Manager, Cheshire Ireland’s Risk Manager/Health & Safety Co-ordinator.

Proposed Timescale: 31/03/2015

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:

All still did not have up to date knowledge and skill appropriate to their role to respond to behaviour issues and to support residents to manage their behaviour.

Action Required:

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

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

Nineteen staff have now participated in the approved Communication & Conflict training. This training took place on the 18th December 2014. Further training for the remaining staff will be carried out by March 31st 2015

Responsible Individual(s): Service Manager supported by the Clinical Education Facilitators

Proposed Timescale: 31/03/2015

Theme: Safe Services

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

All staff had not received training in positive behaviour techniques, in de-escalation techniques and positive intervention techniques.

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:

Nineteen staff have now participated in the approved Communication & Conflict training. This training took place on the 18th December 2014. Further training for the remaining staff will be carried out by March 31st 2015

Responsible Individual(s): Service Manager supported by the Clinical Education Facilitators

Proposed Timescale: 31/03/2015

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 updated training in the recognition and prevention of adult abuse.

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 updated Adult Protection Training completed. Training took place on 5th January 2015

Responsible Individual(s): Service Manager, Service Quality Officer

Proposed Timescale: 18/02/2015

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:

Appropriate and suitable practices were not in place to ensure that medications which were prescribed for a resident were administered correctly and signed as administered.

Action Required:

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

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

A CNM I is due to commence employment within the service in mid-February. This post will be rostered over seven days. The Service Manager and the CNM I (or designates) will commence a daily audit of Medication Administration Record Sheets to ensure that all errors are identified and responded to in a timely manner.

In consultation with the Public Health Nursing service (who provide support to Kerry Cheshire with the administration of controlled drugs), arrangements have been made to ensure that, where a PHN administers these drugs, Cheshire Ireland Medication Administration Sheets will be signed by the administering PHN.

A quarterly Peer Audit will be undertaken with full review of the quality and accuracy of all documentation of administration, prescription and error management of medication. External analysis of audit returns by the Clinical support services team will identify trends in these audits. A report of this analysis will be used to inform further training and service development in medication management practice within the service.

Responsible Individual(s): Service Manager, CNMI, Clinical Support Services team

Proposed Timescale: 09/02/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The centre did not have a clearly defined management structure in place that identified the lines of authority and accountability, specifies roles, and delegated responsibilities for all areas of service provision.

Action Required:

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

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

An immediate Action Plan was developed (which was satisfactory to the inspector on the day) and immediately implemented. A suitable qualified individual now acts as the PPIM in the absence of the Service Manager.

Proposed Timescale: 18/02/2015

Theme: Leadership, Governance and Management

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

Management systems were not in place to ensure that the service was safe, as there was a lack of staff supervision when the person in charge was not in the centre.

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:

An immediate Action Plan was developed (which was satisfactory to the inspector on the day) and immediately implemented. A suitable qualified individual now acts as the PPIM in the absence of the Service Manager.

Proposed Timescale: 18/02/2015

Theme: Leadership, Governance and Management

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

Due to the depleted management team there was no system in place for performance management of staff or for regular staff appraisals.

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:

A restructuring of the management team within the service is currently taking place. Organisationally Cheshire Ireland has introduced a performance management process to manage employees' performance. This is a competency based one to one performance review system. Commencement of the roll out of this system will occur within the service. Completion of this roll out process will take 6 months. In line with the Performance Management system, the Service Management will schedule 1:1 performance review meetings with staff who report directly to them on a regular basis. The minutes of these meetings will be recorded and agreed by both parties using the template form. All minutes of these meetings are recorded and meetings will be schedule to occur on a 6 weekly basis.

On the spot mentorship, guidance and supervision is also provided by the Service Manager within the service and any performance issues / training needs identified are addressed within a reasonable timeframe by the Service Management.

Responsible Individual(s): Regional Manager, Service Manager, Cheshire Ireland's Human Resources Department

Proposed Timescale: 31/08/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

There were insufficient staffing resources in the centre to meet the needs of the residents and to enable them to fulfil their goals. Entries in the complaints log supported this as a number of complaints involved residents waiting a long time for help and some staff being rushed and appearing brusque when attending to residents.

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:

Immediate action was taken following the inspection and a suitable qualified individual now acts as the PPIM in the absence of the Service Manager. A meeting between the Service Manager, Cheshire Ireland's Chief Executive and the HSE was held in October 2014 regarding this issue and the resources available to Kerry Cheshire. Cheshire Ireland are currently awaiting a response from the HSE. On 23/01/2015 senior members of Cheshire Ireland staff (including a representative from the Human Resources Department) met with SIPTU regarding the staffing compliment within Kerry Cheshire. A needs analysis and subsequent contracts review is taking place to identify the staffing requirements and skill mix of staff required to meet the assessed needs of the residents. A new roster will be developed by the Service Manager to ensure the supports required can be provided.

Responsible Individual(s): Chief Executive, Regional Manager, Service Manager (with the support of Cheshire Ireland's Human Resources Department)

Proposed Timescale: 30/09/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

The number, qualifications and skill mix of staff was not always appropriate to the number and assessed needs of the residents, the aspirations in the statement of

purpose and the size and layout of the designated centre.

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:

Immediate action was taken following the inspection and a suitable qualified individual now acts as the PPIM in the absence of the Service Manager. A meeting between the Service Manager, Cheshire Ireland's Chief Executive and the HSE was held in October 2014 regarding this issue and the resources available to Kerry Cheshire. Cheshire Ireland are currently awaiting a response from the HSE. On 23/01/2015 senior members of Cheshire Ireland staff (including a representative from the Human Resources Department) met with SIPTU regarding the staffing compliment within Kerry Cheshire. A needs analysis and subsequent contracts review is taking place to identify the staffing requirements and skill mix of staff required to meet the assessed needs of the residents. A new roster will be developed by the Service Manager to ensure the supports required can be provided.

Responsible Individual(s): Chief Executive, Regional Manager, Service Manager (with the support of Cheshire Ireland's Human Resources Department)

Proposed Timescale: 30/09/2015

Theme: Responsive Workforce

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

Not all staff had been afforded updated and refresher training in medication management training and infection control training relevant to their role.

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:

A CNM I is due to commence employment within the service in mid-February. Outstanding supervision and assessment for trained care staff will be completed by mid-March. Recently recruited staff will receive Medication Management Training on 26th March 2015 and will receive follow up supervision and assessment prior to administering medication independently. Refresher training will be rolled out for remaining staff in late April and May.

Training in environmental hygiene and infection control will be provided to all staff over the next three months.

Responsible Individual(s): Service Manager, CNMI, Clinical Support Services team

Proposed Timescale: 30/06/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Not all the policies in the centre were reviewed within the regulatory requirement of three years.

Action Required:

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

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

All responsible individuals within the organisation have been contacted regarding updating any policies which require review.

The complaints policy and procedure is currently under review by the service quality officer

An electronic Quality Management System is currently being researched and sourced by Cheshire Ireland's National Risk Manager. 2 companies made presentations to some members of Cheshire Ireland's Senior Management Team on 22nd January 2015. Both systems contain an electronic document system. This topic will be discussed at Cheshire Ireland's next Senior Management meeting a process for implementing a new system will be discussed.

Proposed Timescale: All policies reviewed and updated by 30/04/2015

New QMS to be purchased and implemented by 01/01/2016

Responsible Individual(s): Cheshire Ireland's Senior Management team

Proposed Timescale: 01/01/2016

Theme: Use of Information

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

Not all records required under Schedule 2 of the Regulations were maintained for staff.

Action Required:

Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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:

An audit of all staff files against the requirements within Schedule 2 of the regulations will be carried out by the Service Manager. All reasonable efforts will be made to obtain (on a retrospective basis) any of the required documents identified as not being located

within the files.

Responsible Individual(s): Service Manager

Proposed Timescale: 13/03/2015

Theme: Use of Information

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

All records required to be maintained for inspection under schedule 3 of the Regulations were not maintained in the centre, for example, records of medication errors, and signatures of nurses and staff members administering medication.

Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

Maintenance of medication administration records will be covered as part of the content in the Medication Management training. The Service Manager and the CNM I (or designates) will commence a daily audit of Medication Administration Record Sheets, which will identify immediately any errors / gaps in the medication administration records.

In consultation with the Public Health Nursing service (who provide support to Kerry Cheshire with the administration of controlled drugs), arrangements have been made to ensure that, where a PHN administers these drugs, Cheshire Ireland Medication Administration Sheets will be signed by the administering PHN.

Responsible Individual(s): Service Manager, CNMI, Clinical Support Services team

Proposed Timescale: 09/02/2015