

**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-0003457
Centre county:	Waterford
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Caroline Connelly
Support inspector(s):	Kieran Murphy and Michelle O Connor
Type of inspection	Announced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	4

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:
24 November 2015 10:00	24 November 2015 18:00
25 November 2015 08:30	25 November 2015 18:00

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

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

Summary of findings from this inspection

This was a registration inspection of a Cheshire Ireland service in Waterford which is one of a number of designated centers that come under the auspices of Cheshire Ireland. Cheshire Ireland provides a range of residential, and respite services throughout the country. Cheshire Ireland is governed by a board of directors. The responsibility for the operation of the organisation is delegated to a Chief Executive Officer (CEO) and a senior management team. The CEO is the nominated provider for the service. This centre provided care for residents with physical disabilities and neurological conditions.

The facility provided accommodation to 13 residents, with three vacancies for the provision of respite care. There was the capacity to accommodate 18 residents in total. Each resident had an accessible self contained apartment. A number of apartments were located on the first floor and were accessible by lift. The lift doors opened automatically on approach, thus no use of hands was required. Some other apartments were used as offices for other community services. The premises was seen to be purpose built and provided accommodation of high quality which was very clean and well maintained.

The registration inspection took place over two days and during this time the inspectors met residents, relatives the regional manager, the acting person in charge, the Clinical Nurse Manager (CNM), senior care workers and numerous staff members. Throughout the inspection inspectors observed practices and reviewed documentation which included residents' records, policies and procedures in relation to the centre, medication management, accidents and incidents, complaints, health and safety documentation and staff files. Since the last inspection in March 2014 there had been two changes to the person in charge and the Authority had not received notification that the previous person in charge had left the service. There was an acting person in charge who had only been in post two weeks prior to the inspection but had worked in the service for nine years. The acting person in charge worked full time and was seen to be very involved in the day-to-day running of the overall service. Staff and residents informed inspectors that he was accessible to residents, relatives and staff.

A number of questionnaires from residents and relatives were received and the inspectors spoke to the residents and a number of relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. However, there were some concerns expressed in relation to staffing levels particularly in the mornings and issues around some residents not being able to self administrate their own medications. These issues were looked into during the inspection and are discussed under the relevant outcomes.

There was evidence of individual residents' needs being met and the staff supported and encouraged residents to maintain their independence where possible. Community and family involvement was evident and encouraged as observed by inspectors. Many residents went home for varying periods and were out regularly during the day. The inspectors observed evidence of good practice during the inspection and were satisfied that residents received a good standard of health care with appropriate access to their own general practitioner (GP), psychiatry and allied health professional services as required. However, the inspectors found that there were five major and six moderate non compliances with the regulations and identified substantial improvements required in relation to availability of staff and nursing staff cover at weekends and holiday relief, management of residents discharge from the service, admission policy and contracts of care, residents finances and protection, and health and safety. The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centers for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.

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:

Inspectors observed staff interaction with residents and noted staff promoted residents dignity while also being respectful when providing assistance. There was evidence that residents were consulted about how the centre was organised and residents meetings had taken place. The inspectors saw minutes of a residents meeting that took place between residents staff and the health and safety officer on the 11 November 2015 to discuss proposals for a new building beside their home and how it would effect them. A previous meeting had taken place in October 2015.

Inspectors were satisfied that there was an effective complaints process in place to facilitate and support residents and/or their relatives to make a complaint. There was a local complaints policy and the centre did maintain a complaints log. The complaints log outlined the complaint, investigation, action taken and recorded if the complainant was satisfied with the outcome of the complaint.

Inspectors were informed that one resident was a ward of court (called a wardship). While there was documentation available in the centre in relation to the wardship for the resident it wasn't clear if it extended to the resident's personal care or if it was confined to his financial affairs. There was evidence that financial decisions made by and on behalf of the resident had been approved through the office of the wards of court.

The person in charge informed inspectors that he monitored safe-guarding practices by regularly speaking to residents and their representatives, and by reviewing the systems in place to ensure safe and respectful care was provided. Inspectors observed staff endeavouring to provide residents with as much choice and control as possible by

facilitating residents' individual preferences for example in relation to their daily routine, meals, assisting residents in personalising their apartments and their choice of activities. Residents all had their own self-contained apartments which promoted their privacy and dignity. The inspectors saw very personalised living arrangements in residents' apartments with photographs, personal effects and furniture. There was plenty of space for clothes and personal possessions in all apartments with wardrobes, cupboards and lockers.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

The inspectors noted that residents had access to appropriate media, such as television, and radio. All residents had televisions in their apartments and many had their own computer/laptops and had access to the internet as required.

There was a communication policy available on the day of inspection and staff who spoke to the inspector demonstrated great awareness of individual communication needs of residents in their care and could outline the systems that were in place to meet the diverse communication needs of residents. In addition, inspectors noted that individual communication requirements, including residents with complex communication needs, had been highlighted in personal plans and were also reflected in practice. For example, the inspectors noted that staff used communication approaches such as gestures, signals, facial expressions and vocalisations to communicate with some residents. Residents were observed to use electronic type dicta phones and spell charts to aid and assist communication and the inspectors met and communicated with numerous of the residents throughout the inspection.

Inspectors noted from residents' personal plans that there had been input from multi-disciplinary professionals including speech and language therapists and occupational therapists to assist residents meet their range of communication needs. Staff to whom inspectors spoke outlined how residents were facilitated access, where required, to technology and communication aids.

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 inspectors noted there was generally an open visiting policy and relatives could visit without any restrictions. As residents all had their own apartments private visiting was facilitated and there was also a quiet room and a sitting room that residents could use for visiting if they did not wish to use their apartment. The inspectors met a number of visitors in the centre during their inspection. There was evidence in residents' personal plans showing visitors attending the centre at different times as well as regular planned visits and this was confirmed by relatives that spoke to the inspectors.

The inspectors saw and relatives confirmed that they were updated as required in relation to residents' progress and many relatives attended residents' review meetings. The inspectors saw in residents' personal plans that these meetings were held on a regular basis. There was evidence that residents' representatives could bring any issue directly to staff. Relatives spoken to and questionnaires confirmed to the inspectors that staff were very responsive to any such issues raised.

The inspectors saw that residents were supported to develop and maintain personal relationships and links with the wider community, and families are encouraged to be involved in the lives of residents. One resident's wife lived with him and other residents visited their family homes and relatives, and this was all documented as part of their personal plans. Overall, the inspectors saw evidence of good family involvement in care.

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):

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

Findings:

There were three documents outlining admissions to and the contract for the provision of services in Waterford Cheshire, the statement of purpose, a service agreement and a tenancy agreement.

The service agreement was in writing and outlined the terms on which each resident resided there. The agreement also outlined the support care and welfare of the resident and the details of the services to be provided for that resident. Inspectors found that not all residents had signed their service agreement. In addition, for one resident there has been a service agreement between the Health Services Executive and Cheshire Waterford. However, there wasn't any signature by or on behalf of the resident in relation to this service agreement.

The tenancy agreement set out obligations in relation to issues like rent, landlord duties, premises, absences, breach of agreement and termination. However, as was found on the previous inspection neither the service agreement nor the tenancy agreement outlined the provisions whereby a resident may be requested to vacate the service due to ill health.

The service agreements did not outline the fees that residents were being charged for services. For example, the service agreement for one resident said that transportation was "to be provided with support to access public transport, taxis, et cetera to enable you to get out and about". However, this resident was being charged for transportation and the fees were not outlined in the service agreement.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

At the last inspection inspectors found that the arrangements for discharge of residents were not transparent. There was not any evidence that a discharge would take place in a planned and safe manner. At that time the person in charge informed inspectors that a resident had never been discharged from Cheshire Waterford. Since then one resident had been discharged from the service to a nursing home. Inspectors were not satisfied that the discharge from Cheshire Waterford had taken place in a planned and safe manner. This discharge had taken place without the resident being given the opportunity to ensure that they were satisfied with the environment and the supports which were being offered in the nursing home. Inspectors were informed that the next day following the transfer to the nursing home the resident had been discharged by the nursing home to a medical ward in an acute general hospital. Inspectors were also informed that the service would not be taking the resident back.

The inspectors reviewed a selection of personal plans which were found to be very comprehensive. They were very personalised, detailed and reflected resident's specific requirements in relation to all their needs and activities that were meaningful to them. There was evidence of ongoing monitoring of residents needs including residents' interests, communication needs and daily living support assessments. There was a system of key workers in operation whose primary responsibility was to assist the individual to maintain their full potential in relation to the activities of daily living. Inspectors were informed that support staff who worked with the residents fulfilled the role of individual residents' key workers in relation to individual residents care and support. These key workers were responsible for pursuing objectives in conjunction with individual residents in each resident's personal plan.

There was some evidence of interdisciplinary team involvement in residents' care including, medical and General Practitioner (GP), speech and language, dentist and chiropody services. These will be discussed further in Outcome 11 healthcare needs. There was evidence in some residents' personal plans that the resident and their family members where appropriate, were involved in the assessment and review process and attended review meetings.

The residents told the inspectors there had been an increase in social outings and activities following the appointment of the previous person in charge. Residents said how much they enjoyed getting out and being involved socially within the centre and hoped this would continue with the new person in charge.

In relation to situations where residents were transferred to an acute general hospital for procedures inspectors were satisfied with the sharing of information between the hospital and the centre. The clinical nurse manager arranged meetings with the clinical team in the hospital and received comprehensive information regarding the treatment the resident had received in the hospital. The care plans prepared by the clinical nurse manager following discharge back to the centre reflected any instructions received from the treating doctor in the hospital.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Accommodation was provided in a sheltered housing project which consisted of 22 accessible self contained apartments. 13 apartments were at ground level, with most of these apartments having their own patio or garden area. Seven apartments were located on the first floor which were accessible via a lift. All apartments had a kitchen/dining area, an accessible shower/toilet area and a bedroom. A small number of apartments had a second bedroom. There was a call bell system in place throughout the complex.

There was a main reception area to the front of the building. There was a resource room available for community groups and a number of residents attended activities co-ordinated by external voluntary organisations. There was a library room in the reception area also. There was a physiotherapy room upstairs available to residents following physiotherapy programmes.

Waterford Cheshire also served as a community resource with the offices of a number of community organisations based in the complex.

The accommodation was found to be of a high standard and very clean throughout. Residents individual apartments were much personalised. There was plenty of gardens and outdoor space with suitable seating for residents to use and enjoy.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

implemented.

Findings:

Since the last inspection the risk management policy had been updated and included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. There was a process in place for hazard identification and assessment of risk throughout the designated centre with some hazards being specifically addressed. For example, the service had undertaken a risk assessment of a tree outside one resident's apartment. However, some risk assessments were not always being followed. For example, access to the laundry area had been assessed as a hazard due to chemicals being available in the room. The controls included a digi-lock on the door to restrict access but on the day of inspection there was free access to the laundry room.

The centre had a risk register in place. An organisation risk register is designed to log all the hazards that the organisation was actively managing. However, the methodology of assessing risk on the risk register i.e. whether the risk was low, medium or high was not the same method as outlined in the Cheshire Waterford risk management policy. It wasn't always clear how the hazards on the risk register were being managed and who was responsible. For example, the storage of compressed medical oxygen did not outline the date action was to be taken or who was responsible for managing this hazard. It was also unclear if hazards on the risk register were being escalated to the management team of Cheshire Ireland.

There was an incident reporting system in place and inspectors saw records for 102 incidents from May 2015 to November 2015. These included:

- 54 medication management errors
- 29 incidents of verbal abuse by residents to staff

The types of medication management errors included medication being administered but not being signed for, discontinued medication being given to residents when the doctor had stopped the medication and blood clotting levels not being available for residents taking warfarin. Some of these issues related to residents taking their own medicine (self medicating) and that is discussed in more detail in outcome 12: medication management. Inspectors also spoke to the clinical nurse manager who was responsible for supervising the clinical care given to residents. The clinical nurse manager outlined that she was now providing training to care staff on medication management and was always available to give advice to care staff in relation to medication management.

In relation to fire safety improvement was required. As found on the previous inspection, not all staff had received fire safety training. Inspectors saw that one fire door in the apartment of one resident had been wedged open with a facecloth.

The inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:

- Servicing of fire alarm system and alarm panel November 2015
- fire extinguisher servicing and inspection December 2014
- servicing of emergency lighting November 2015.

Fire evacuation maps were displayed prominently and there had been six fire evacuation

drills since December 2014, with the most recent in November 2015. Each resident had their own personal evacuation plan.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

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

Findings:

There was an up to date policy on, and procedures in place for, the prevention, detection and response to abuse.

There were comprehensive systems in place to respond to any allegation of abuse. Investigations, seen by inspectors, had been undertaken by the service manager and reviewed by the regional manager and the service quality manager of the organisation. These investigations had followed up allegations appropriately and the outcome had been communicated in an open and transparent manner. Staff with whom inspectors spoke knew what constituted abuse. However, not all staff were trained in the prevention, detection and response to abuse as required by the legislation this was non compliance identified on the previous inspection and remained non compliant on this inspection.

There was an up to date policy on the use of restraint which was in line with evidence based practice. The policy outlined that consent to the use of restraint had to be obtained from the resident, and also that there had to be multidisciplinary assessment of the appropriateness of restraint. Restraint in this context included lap belts, bed rails and tables on wheelchairs. Inspectors also saw a register of all the types of restraint which were in use. However there were not comprehensive assessments in place for the requirement for restraint and there was no evidence of consideration of least restrictive alternatives to the use of restraint as required by national policy and evidence based practice.

There was a policy on challenging behaviour however there was little evidence in

residents' personal plans that detailed behavioural support plans were in operation for residents who presented with behaviours that challenged and detailed de-escalation techniques were not outlined. There was evidence of review by the psychiatrist but there was little input from a psychologist and no behavioural plans prescribed. Training records and staff confirmed that not all staff had received up-to-date training in the management of behaviours that challenged.

The inspectors reviewed the system in place to manage residents' finances and overall the inspectors were not satisfied that the system was sufficiently robust to ensure the safeguarding of residents. The person in charge informed the inspectors that most resident's finances are kept in their own apartments and spending is signed in and out by staff. However inspectors noted there was only one staff signature on numerous transactions and no regular ongoing checks and audit which did not protect the residents or staff. The inspectors saw evidence that one resident was paying for transport for a number of years that was provided by the service and other residents were not paying for this transport. There was no evidence where this payment had been initiated and agreed. This payment was not outlined in the residents contracts of care as discussed previously and the inspectors were not satisfied that there were robust systems, policies and procedures in place to protect residents from misuse of the systems, particularly in the payment for transport by one resident only.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector saw that there was a process for recording any incidents that occurred in the centre and the procedure for maintaining and retaining suitable records as required under legislation. All incidents and accidents were recorded in a comprehensive incident log and a copy was sent to the person in charge for checking and for countersigning all incidents/accidents. The team also outlined the arrangements to ensure that a written report was provided to the Authority following any notifiable incident and at the end of each quarter period of any occurrence in the centre of any incident as required.

The authority received all notifications to date in a timely manner as required by legislation.

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:

The inspectors were satisfied that residents' opportunities for new experiences, social participation, education, training and employment were facilitated and supported. There was a policy on access to education, training and development. Inspectors noted that opportunities for further education were afforded to residents and the educational achievements of residents were valued. Many of the residents had their own laptops, computers and printers.

One of the residents worked for a local organisation and a resident on respite was attending college.

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 healthcare needs were met through timely access to GP services. The inspectors saw that residents were assisted to access community-based medical services such as their own GP. They were supported to do so by staff who would accompany them to appointments if required and assisted in collecting the prescription as required. Out-of-hours services were provided by the local on call doctor service who attended the resident at home if necessary. Residents were actively encouraged to take responsibility for their own health and medical needs. Residents maintained control of their medical information in their own apartment.

There was evidence in residents' records of referrals to and assessments by allied health services and plans put in place to implement treatments required. The centre was nurse-led and the inspectors saw there were a number of validated tools in place for dependency, falls, nutrition and pressure sore formation. The inspectors found there were a number of residents with complex physical and nursing needs and were assessed as having maximum dependency needs. The inspectors acknowledged that measures and equipment were put in place such as a specialist mattresses, hoists and chairs. However the inspectors found, as outlined in outcome 17, that there was a requirement for extra nursing staff to prescribe and direct the care required for these residents at the weekends. The resident's health support file contained nursing notes, doctors' notes, and reference to other health professionals like speech therapy, dietetics and physiotherapy and there was evidence of an annual review of residents' care needs by the GP.

The CNM supervised clinical care and delegated care to non nursing staff. The CNM also provided training to staff on different aspects of clinical care that may arise like catheter care, percutaneous endoscopic gastrostomy (PEG) feeding and stoma care. There were very comprehensive care plans seen that fully outlined the care required supporting residents to achieve the best possible health. Comprehensive plans were also seen to be in place for end of life care and the centre involved the community palliative care team as required.

In relation to food and nutrition residents were supported by staff to prepare meals in their own kitchen in their apartments. Residents discussed meal plans with staff. There was evidence of monitoring and documentation of nutritional intake with residents' care plans outlining arrangements in relation to diet. In communal areas there was access to snacks and drinks if required.

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):

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

Findings:

The inspectors saw that the centre uses the Cheshire Ireland organisational policy on medication management but the policy was not centre specific and therefore did not outline local arrangements., this is actioned under outcome 18 in relation to records.

Medication was dispensed by a pharmacist in tamper proof packs every four weeks. The dispensed medication was colour coded in relation to administration times. The medication administration record sheet had a picture of each medication with a description of the medication included. When medication was dispensed by pharmacy the prescription was checked against the medication administration record.

Inspectors saw that the CNM transcribed the prescription on to the medication administration sheet. This transcription was then signed as accurate by the GP. However the signature of the transcribing nurse was not documented on the transcription as required by best practice guidelines.

There was evidence that some residents were encouraged to take responsibility for their own medication in accordance with their wishes and preferences. There was a policy on self administration of medication however the policy had recently been changed and the new assessment prevented a number of residents from self medicating due to their physical disability. Residents were very upset with this decision and a number of residents met with the inspectors to discuss same. The person in charge informed the inspectors that the service were currently looking at this and had set up a working group which included a number of the residents to review the policy and practice and to establish a safe and workable system for all.

Inspectors found there were appropriate procedures for the management of controlled drugs. There was a locked cupboard inside a locked cupboard for the secure storage in residents apartments and a system was recently implemented to check the stock at the beginning and end of each shift.

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):

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

Findings:

There was a written statement of purpose that described the service provided.

On the previous inspection it was identified that the services and facilities outlined in the statement of purpose for the most part did reflect the manner in which care was

provided and reflected the diverse needs of residents. The only restriction to care provision outlined in the statement of purpose was that individuals seeking to access the services had to be between the ages of 18 and 65 when they first arrived. There was no reference in the statement of purpose to alternative accommodation being sought in the event of a change in a resident's dependency level. On this inspection this remained outstanding and the inspectors found that the statement of purpose did not contain all the relevant information to meet the requirements of Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It did not clearly outline the number of apartments and which apartments formed part of the centre. It also did not reflect changes to the person in charge and to the senior management team.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Cheshire Ireland provide a range of residential, and respite services throughout the country. Cheshire Ireland is governed by a board of directors. The responsibility for the operation of the organization is delegated to a Chief Executive Officer (CEO) and a senior management team. The CEO is the nominated provider for the service and the service manager for the centre is the person in charge. There is a regional manager who is responsible for a number of centres and the person in charge for the centre reports to her. Since the last inspection in March 2014 there had been two changes to the person in charge. There was an acting person in charge who had only been in post two weeks prior to the inspection but he had worked in the service for nine years. The acting person in charge worked full time and was seen to be very involved in the day-to-day running of the overall service. Staff and residents informed inspectors that he was accessible to residents, relatives and staff.

The person in charge is supported in his role in the centre by the CNM and senior support workers as part of the day to day management team. There was evidence that the person in charge had a commitment to his own continued professional development.

The inspectors formed the opinion that he fully knew all the residents and their needs and had the knowledge to ensure the effective care and welfare of residents in the centre.

Inspectors noted that residents and relatives were familiar with the acting person in charge and said they could speak to him if necessary. Staff who spoke to the inspectors were clear about whom to report to within the organisational line and of the management structures in the centre. The senior support worker or the CNM takes responsibility for the centre in the absence of the person in charge.

Inspectors noted that the person in charge and staff generally demonstrated a positive approach towards meeting regulatory requirements. The provider had employed the services of a consultant to undertake a full eighteen outcome review of the service focusing mainly on areas that required improvement. This comprehensive review had taken place in July 2015 and numerous actions and improvements required were identified. However, there was little evidence of action taken to address these issues and the inspectors found there were ongoing non compliances identified from the previous report. There was evidence of some quality audits being undertaken such as audits of adverse incidents and medication audits, however inspectors found that these were not consistent and there was not an ongoing comprehensive review of the quality and safety of the service and of the care provided. There was no evidence of the provider or a nominee on behalf of the provider undertaking unannounced visits of the centre and there were no reports available. There was also no annual review completed as required by legislation.

The inspectors were not satisfied that the system implemented to monitor the quality of care and experience of the residents was adequate to ensure the delivery of safe, effective services.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge

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

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There had been a number of changes to the person in charge since the previous inspection. The previous person in charge vacated this post over two weeks prior to the

inspection. However, the authority was not notified of the absence of the person in charge as is required by legislation. The senior support worker commenced the acting person in charge role in recent weeks. The provider also did not notify the chief inspector in writing of the procedures and arrangements that were put in place for the management of the designated centre during the absence of the person in charge also as required by legislation.

The regional manager told the inspectors they had advertised for the role of person in charge and were hoping to interview in the near future.

Judgment:
Non Compliant - Major

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 inspectors formed the opinion that the centre was generally resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose. However, the inspectors noted that there was only one bus available to accommodate residents transport needs and this bus did not provide accessible transport services for a number of the residents who have large chairs therefore these residents have to book and pay for transport from another service. If this transport was not available the resident would not be able to get out. The regional manager said they have looked for funding for a more suitable vehicle that will meet the needs of all of the residents but this had not been made available to date.

The inspectors saw that there was sufficient assistive equipment to meet the needs of residents with servicing records for assistive equipment up-to-date. The person in charge told the inspectors that the residents' care would not be compromised by budget constraints and if specialist equipment was required, funding would be provided.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors spoke to staff and observed them at work with the residents. Staff were knowledgeable about each resident's needs and interacted with them in a respectful and dignified manner. Inspectors also spoke to some family members who were very complimentary about the staff that worked in the centre. Some residents had their own dedicated staff teams providing one-to-one care. This arrangement ensured continuity of care. Some residents managed their own staffing allocation and residents were involved in the recruitment and selection of these staff.

Many staff had completed training which was required as mandatory by the regulations however the inspectors identified a number of staff who did not have all the required mandatory training which included updated adult protection training. It was also identified that a large number of staff did not have training in behaviours that challenge, and these are actioned separately under outcome 8.

Inspectors reviewed a sample of staff files and although they contained evidence of Garda Síochána vetting, written references, photographic identification and detailed work histories, the inspectors found that staffs relevant qualifications were missing in a number of staff files. Therefore they did not meet the regulatory requirements.

Residents and relatives told inspectors that they were not satisfied that staffing levels in the morning met the needs of the residents with some residents reporting that they had to wait long periods of time for staff to assist them. The CNM was a registered nurse who had responsibility for ensuring that each resident had care which was appropriate and evidence based. This responsibility extended to clinical supervision of all non-nursing staff. She was employed during the day Monday to Friday. There was no nursing staff on duty at night, and no nurse on duty at the weekend. Also when the nurse was on leave, study days or days off there was no replacement. Due to the complex and maximum dependencies of many of the residents inspectors formed the opinion that while the quality of care was good this level of supervision of care was not adequate and these nursing arrangements required review and this was outlined at the feedback meeting.

There was evidence of staff meetings held which included records of relevant and ongoing issues discussed.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

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 were generally maintained. The centre was adequately insured against accidents or injury to residents, staff and visitors. Staff to whom inspectors spoke demonstrated an understanding of specific policies such as managing allegations of adult abuse in practice. However, the inspectors reviewed the centre's policies and procedures and found that although the centre did have 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. A number of policies required review which included the emergency policy which was not up to date with the current residents and the medication policy as discussed under outcome 12 did not fully address self medication and was not centre specific.

The inspectors reviewed the directory of residents and noted that the directory was completed for each resident and generally contained the required information with the exception of marital status and sex of the resident.

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:

Caroline Connelly
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-0003457
Date of Inspection:	24 November 2015
Date of response:	30 December 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 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:

There was not clear documentation relating to the wardship arrangement for one of the residents.

1. Action Required:

Under Regulation 09 (1) you are required to: Ensure that the designated centre is

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

operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

The PIC has contacted Office of the Ward of Court looking for clarification of their wardship responsibilities and is awaiting a response. The response will be documented in relation to arrangements for the resident in question.

Proposed Timescale: 15/01/2016

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:

Neither the service agreement nor the tenancy agreement outlined the provisions whereby a resident may be requested to vacate the service due to ill health.

2. Action Required:

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

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

1. The current policy regarding admission and discharge of residents is being reviewed as part of an organisational HIQA action plan which is to be completed by 31/3/2016.
2. Service agreements and tenancy agreements review has begun and will be updated to reflect the changes to the policies.

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

One resident was being charged for transportation and the fees were not outlined in the service agreement.

3. Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

A complaint into this matter was completed on behalf on SU in question.
A preliminary enquiry was completed and recommended that a formal investigation into the issue is commenced under The Provider Adult Protection Policy and Procedure.
An external investigator has been sourced and they have completed the preliminary work for the Investigation on 15/12/2015.
A report from investigator is pending.

Proposed Timescale: 15/01/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

A discharge had taken place without the resident being given the opportunity to ensure that they were satisfied with the environment and the supports which were being offered in the nursing home.

4. Action Required:

Under Regulation 25 (4) (b) you are required to: Discharge residents from the designated centre in a planned and safe manner.

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

1. The current policy regarding admission and discharge of residents is being reviewed as part of an organisational HIQA action plan which is to be completed by 31/3/2016

Proposed Timescale: 31/03/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The risk assessments were not always being followed. For example, access to the laundry area had been assessed as a hazard due to chemicals being available in the room. The controls included a digi-lock on the door to restrict access but on the day of inspection there was free access to the laundry room.

5. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

1. Appropriate signage in relation to keeping the door locked has been placed on the

Laundry door and access to the area will be monitored by staff on each shift.
2. The Provider's Health and Safety Officer will complete a localised risk register to manage risks and implement risk actions within the centre in January and February 2016. This will begin on 7/1/2016.

Proposed Timescale: 29/02/2016

Theme: Effective Services

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

The methodology of assessing risk on the risk register, i.e. whether the risk was low, medium or high, was not the same method as outlined in the Cheshire risk management policy.

6. 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 Provider's Health and Safety Officer has arranged to visit the centre in January and February 2016 to build a localised risk register to manage risks and implement risk actions. As part of this key staff in the service will be identified and will be given risk management/assessment training.

Proposed Timescale: 29/02/2016

Theme: Effective Services

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

The organisation risk register required review.

7. 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:

1. The current policies are being reviewed as part of an organisational HIQA action plan which is to be completed by 31/3/2016

2. The Provider's Health and Safety Officer has arranged to visit the centre in January and February 2016 to build a localised risk register to manage risks and implement risk actions.

3. An Emergency Evacuation Plan will be updated to include all service users and the names of respite users who frequently use the service will be incorporated in. completed by 15/1/2016.

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

One fire door in the apartment of one resident had been wedged open with a facecloth.

8. Action Required:

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

1. It has been communicated to all staff that doors are not to be wedged open. This will be monitored closely by the PIC and PPIM.
2. Staff have been identified who require Fire and Safety training. This training will take place on 19/1/2016.

Proposed Timescale: 19/01/2016

Theme: Effective Services

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

As on the previous inspection not all staff had received fire training.

9. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

Staff have been identified who require Fire Safety training. This training will be held on 19/1/16.

Proposed Timescale: 19/01/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There were not comprehensive assessments in place for the requirement for restraint and there was no evidence of consideration of least restrictive alternatives to the use of restraint as required by national policy and evidence based practice

10. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

A Full review into the use of restraints with all residents has begun; this will include an assessment on the requirement of the restraint and a report on the feasibility of less restrictive methods where appropriate.

Proposed Timescale: 30/01/2016

Theme: Safe Services

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

Training records and staff confirmed that not all staff had received up-to-date training in the management of behaviours that challenged.

11. 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:

Staff have been identified who require training into management of behaviours that challenge. A company has been contacted and this training will take place on the 25th February 2016

Proposed Timescale: 25/02/2016

Theme: Safe Services

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

The systems in place to manage residents finances were not sufficiently robust.

12. Action Required:

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

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

1. In regard to Service User who is a ward of court
An external investigator has been sourced and they have completed the preliminary work for looking into SU's spending. The investigation took place on 15/12/2015.
A Report from investigator is pending.

2. The Provider's Money Management policy will be rolled out for all Service Users in the centre. This process has already begun.

Proposed Timescale: 29/02/2016

Theme: Safe Services

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

The inspectors saw evidence that one resident was paying for transport for a number of years that was provided by the service and other residents were not paying for this transport. There was no evidence where this payment had been initiated and agreed.

13. Action Required:

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

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

A complaint into this matter was completed on behalf of Service User in question.
A preliminary enquiry was completed and recommended that a formal investigation into the issue is commenced under the Provider's Adult Protection Policy and Procedure.
An external investigator has been sourced and they have completed the preliminary work for the Investigation on 15/12/2015.
A Report from the investigator is pending.

Proposed Timescale: 15/01/2016

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 signature of the transcribing nurse was not documented on the transcription as required by best practice guidelines.

14. Action Required:

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

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

Advice was taken from The Provider's Clinical Support Officer and a new procedure put

in place whereby the transcribing nurse signs the prescription kardex. All completed bar 1, awaiting SU's return from community to complete.

Proposed Timescale: 04/01/2016

Theme: Health and Development

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

The medication policy and practices required review to ensure that following a full risk assessment and assessment of capacity, residents are encouraged to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

15. Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

Medication Management policy review group was formed in December 2015 with the remit of reviewing the current medication management policy to make it person centred and in line with Service Users wishes, preferences and in accordance with the nature of their disability.

This group which includes Service Users, met on December 8th with a follow up meeting due in early January.

Proposed Timescale: 29/02/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not contain all the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

16. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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:

The Statement of purpose to be reviewed and updated with all information set out in Schedule 1

Proposed Timescale: 29/12/2015

Outcome 15: Absence of the person in charge

Theme: Leadership, Governance and Management

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

The Authority were not notified of the absence of the person in charge

17. Action Required:

Under Regulation 32 (1) you are required to: Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

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

The PIC and PPIM attended a workshop on 16/12/2015 which included Notifications and timescales of Notifying HIQA.

Completion of notifications of absence will also be monitored by the Provider.

Proposed Timescale: 16/12/2015

Theme: Leadership, Governance and Management

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

The Authority were not notified of the procedures and arrangements that are in place for the management of the designated centre during the absence of the person in charge.

18. Action Required:

Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.

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

The PIC and PPIM attended a workshop on 16/12/2015 which included Notifications and timescales of Notifying HIQA.

The completion of notifications will also be monitored by the Provider.

Proposed Timescale: 16/12/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

The inspectors noted that there was only one bus available to accommodate residents transport needs and this bus did not provide accessible transport services for a number of the residents who have large chairs.

19. 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:

A funding request to purchase a vehicle which all Service Users can use has been presented to the Provider's Head of Finance.

Proposed Timescale: 31/03/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staffs relevant qualifications were missing in a number of staff files and therefore they did not met the regulatory requirements.

20. Action Required:

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

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

An Audit of all personnel files has begun and will be completed in January 31st 2016 with relevant follow up actions to ensure staff files meet the regulations.

Proposed Timescale: 29/02/2016

Theme: Responsive Workforce

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

There was no nursing care provided at weekends and no cover available for the nurses days off and holidays.

21. Action Required:

Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

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

A Care needs assessment has commenced to determine the number of nursing hours required this needs assessment will be completed by 31st January 2016. A Recruitment process based on those results will begin after that.

Proposed Timescale: 31/03/2016

Theme: Responsive Workforce

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

Not all staff had up to date mandatory training.

22. 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:

Staff who have not up-to-date training have been identified and training will take place during January/ February 2016

Proposed Timescale: 29/02/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

A number of policies required review.

23. 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 Cheshire Ireland policies are being reviewed as part of an organisational HIQA action plan which will be completed by 31/3/2016

Proposed Timescale: 31/03/2016

Theme: Use of Information

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

The directory was completed for each resident and generally contained the required information with the exception of marital status and sex of the resident.

24. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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:

The Marital status and sex of the resident has been added to Service User Register

Proposed Timescale: 30/11/2015