<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003445</td>
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<td>Centre county:</td>
<td>Galway</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider:</td>
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<tr>
<td>Provider Nominee:</td>
<td>Mark Blake-Knox</td>
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<tr>
<td>Lead inspector:</td>
<td>Ann-Marie O'Neill</td>
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<tr>
<td>Support inspector(s):</td>
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About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

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

<table>
<thead>
<tr>
<th>From:</th>
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<tr>
<td>29 October 2014 09:30</td>
<td>29 October 2014 19:45</td>
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The table below sets out the outcomes that were inspected against on this inspection:

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tbody>
<tr>
<td>Outcome 05: Social Care Needs</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 12: Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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**Summary of findings from this inspection**

This was the first inspection of this designated centre to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013.

The inspector met with management, residents and staff members during the inspection. The inspector also observed practice and reviewed documentation such as personal plans, medical records, accident and incident records, meeting minutes, policies and procedures, staff training records and staff files.

The designated centre comprised of a single storey building with offices located near the entrance to the centre and a residential area to the back. Some offices were rented out for use by other groups or organizations not part of Cheshire Ireland. For example, another agency used some offices. A local Mother and Baby/Toddler group used the day room in the centre.

Residents’ accommodation comprised of 10 individual self contained apartments. These were decorated in accordance with residents’ wishes, and their personal belongings were evident.
While the inspector found evidence of a good quality service, improvements were required in the areas of personal planning, risk management, medication documentation, workforce and governance. These are further discussed in the body of the report and included in the action plan.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
Not all aspects of this Outcome were reviewed during this inspection.

Privacy and dignity of residents was generally respected. The inspector observed staff knock and wait for a response before entering residents' apartments. Residents had the opportunity to meet visitors in private in their own individual apartments. Windows for example, had adequate screening to ensure privacy.

There were some environmental enhancements required to ensure privacy was adequately maintained at all times. Parts of the centre’s premises were used as offices for organisations not connected with Cheshire. The main day room was rented out regularly and used to facilitate community groups such as, mother and toddler groups. There was a regular flux of visitors to the building as a result with access to resident corridors. The residential area of the premises did not have sufficient environmental cues or impediments in place so that residents’ privacy was adequately ensured. This required review.

The inspector reviewed how residents’ finances were managed in the centre. Some residents’ parents managed their money, others required individualised levels of assistance and some managed their money independently.

An organisational policy on money management had been drafted in April 2014 and was in the process of being ‘rolled out’. One of the recommended procedures in this new policy was the implementation of a ‘Money Management Questionnaire Evaluation’ for each resident. The purpose of this questionnaire was to ascertain the level of support a
resident may need or if a resident was fully independent.

At the time of the inspection three out of the 10 residents had been assessed using the questionnaire. While it was outlined, by the person in charge, that some residents did not wish to participate in filling in the questionnaire, a record of attempts to engage them in the process was not clearly documented in their personal plans.

Care planning documentation for some residents relating to the management of their finances was not adequate. From the sample reviewed, money management plans had one line stating, ‘to be completed in line with Cheshire policy’. This required improvement to ensure that residents’ finances were being managed in line with their wishes, assessed capabilities and their consent.

**Judgment:**
Non Compliant - Moderate

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**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
All residents living in the centre had personal plans in place. These plans had information relating to residents’ health care needs, transport services, assistive devices or seating arrangements as appropriate to their assessed needs.

Residents’ personal plans contained allied health professional assessments and intervention documentation. A ‘best possible health’ care plan was in place for residents.

An end of life care plan was in place which detailed end of life care wishes and there was evidence of consultation as appropriate.

Residents supported by the community transition co-ordinator, had received social care assessments and person centred plans based on a recognised personal planning process. However, these assessments and associated plans were not maintained in residents’ files in the centre but in the office of the community transition co-ordinator.
The person in charge made provisions for the inspector to review two of these plans. The inspector noted that these were detailed, followed a recognised person centred planning process and indicated positive outcomes for residents.

**Judgment:**
Non Compliant - Moderate

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**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
The inspector found that while the provider had put risk management measures in place, improvement was required. Not all environmental risks and hazards had been assessed. Those identified were brought to the attention of the person in charge throughout the course of the inspection.

There were adequate infection control measures in place. There was an ample supply of alcohol hand gels located around the centre. Universal precautions and care planning was in place for infection control.

Manual handling risk assessments were in place for residents requiring the use of hoists. Individual risk assessments were in residents care plans relating to person specific risks, for example, support with eating and drinking where a resident had an identified risk of choking.

Residents had personal evacuation plans in place. The inspector noted that thumb locks were in place on all doors in the centre, to make evacuation from the centre in the event of a fire easier. Fire drills had occurred three times in 2014 and one was scheduled before the end of 2014.

Fire fighting equipment had been serviced in April 2014. However, the inspector found that servicing for one extinguisher located at the sleep over staff room was out of date. The person in charge made arrangements for the extinguisher to be serviced during the course of the inspection.

A register of various identified risks was maintained in the centre. For each risk identified, control measures, actions taken and dates of completion were documented. However, some control measures identified were not sufficiently robust to reduce the risk of fire breaking out or fire related injuries.
Adequate control measures had not been put in place where flammable products were stored and used in an area where smoking took place. This was brought to the attention of the person in charge, who took action and contacted a fire engineer to visit the centre to review this practice and current control measures. Following the fire engineers visit, some recommendations were made to ensure more enhanced fire prevention measures were in place.

Adequate environmental risk and hazard control measures were not in place for visitors to the centre. A Mother and Toddler/Baby group regularly used the day room in the centre. There were a number of hazards in the premises that the inspector brought to the attention of the person in charge during the course of the inspection. For example, products that posed potential risk were in easy reach throughout the centre such as alcohol hand gels and plastic aprons.

Better ventilation was required for residents that smoked in their apartments. There was a notable smell of cigarette smoke in the communal corridor leading to residents' apartments.

The doors to the ‘ESB press’ were not locked. This press contained electrical cables and trip switch boxes for the centre and apartments of residents. The laundry room and a storage room door were not kept secured. These rooms were used to store chemicals such as bleach and cleaning agents.

**Judgment:**
Non Compliant - Moderate

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**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
Measures were in place to safeguard and protect residents from abuse however, some improvement was required in restraint use.

Residents were protected by the adult protection policy and the abuse reporting and investigation procedures policy both of which had been reviewed in May 2014. These
gave an outline of the procedural stages for responding to and investigating an allegation of abuse.

A policy titled, 'guidelines for supporting people with behaviours that challenge' was available to guide staff. No residents required a behaviour support plan.

A policy to guide staff in the use of restrictive practices had been drafted in May 2013 and reviewed May 2014. The policy set out to promote a restraint free environment within the organisation. It clarified that there were exceptional circumstances in which restraint may act as an enabler. For example, bed rails and lap belts could be appropriately used as part of a service user's assessed need and care plan.

The policy set out descriptions of types of restraint, consent for restraint, multidisciplinary assessment and monitoring. The inspector found evidence of the procedures in the restraint policy in action. Residents that used restraint, such as bed rails or lap belts, had been assessed using the policy guidance tool for assessment. Each restraint used by the resident had an associated risk assessment completed.

There was some improvement needed in the documentation of this. The inspector reviewed a sample of risk assessments for the use of restraint. The document was arranged to assess one specific risk at a time. A list of restraints used by the resident was documented on the restraint risk assessments. Therefore, though restraint had been assessed, the associated risks for each restraint were not adequately outlined as there were a number of entries on the form.

Bed rails used by a resident, at their request, had been assessed using the guidance tool and risks had been identified. The resident however, had asserted they wished to use them despite the identified risk. Risk reduction measures were put in place, but, these were not in line with best practice as measures in place to control the risk of entrapment in themselves, posed a risk of suffocation.

**Judgment:**
Non Compliant - Moderate

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**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
Arrangements were in place to support the healthcare needs of residents, but
improvements were required in the areas relating to evidence based nursing care and care planning.

Residents living in the centre were supported by Health Services Executive (HSE) allied health professionals. Services available to residents were physiotherapy, occupational therapy, speech and language therapy (SALT), dietician and chiropody. Residents had timely access to GP services and out of hours GP services as required.

There was evidence of a good standard of care in relation to seating and positioning of residents. A ‘seating clinic’ was available to residents who required specialised seating and positioning assessment and equipment. Residents had access to mental health day services and review by psychiatry services as required.

There was evidence of systems in place to ensure residents at risk of choking, due to compromised swallow ability, had been assessed by the speech and language therapist (SALT). Residents at risk had care plans in place that gave recommendations for consistency of meals. Staff working in the centre had received training in the management of dysphagia.

Healthcare assessments and care plans were in place for residents. ‘A best possible health’ assessment had been implemented for all residents. This health assessment assessed areas such as communication, skin care, eating, drinking, diet, nutrition. It also assessed residents’ lifestyle, social and spiritual needs.

Care plans were developed following completion of assessment however, the care plans did not always provide adequate detail. For example, care planning for recurrent urinary tract infections required review to ensure evidence based nursing care for the detection, prevention and treatment of urinary tract infection was in place.

Fluid intake and output charts were not being utilised to inform nursing care plans in accordance with evidence based nursing interventions. Records kept did not show documented evidence on their fluid input and output charts or regular testing for signs of infection. (Urinalysis checks) Total volumes were not calculated at the end of each day to ensure residents being assessed were receiving adequate fluids or monitor for dehydration.

Residents identified at risk as per pressure ulcer risk assessments, did not have an associated evidence based nursing care plans in place for detection, prevention and treatment of pressure areas.

**Judgment:**
Non Compliant - Moderate

**Outcome 12. Medication Management**
*Each resident is protected by the designated centres policies and procedures for medication management.*
Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
Not all aspects of this outcome were reviewed on this inspection.

Medications for residents were stored safely in a cupboard in a room with restricted access.

Residents wishing to self administer their medication had undergone a medication administration assessment. The medication policy for the organisation outlined a self administration assessment tool to be implemented when assessing residents’ ability to self administer medication.

A policy relating to the procedures on the administration, storage and disposal of medication was dated August 2014. It outlined the procedures for administration of medication and recording of medication administered. The policy set out that an audit of procedures identified in policy should take place annually.

However, annual auditing of medication procedures was not adequate to ensure medication management practices were being safely enacted. Prior to the inspection a medication audit conducted by the person in charge and regional manager highlighted there had been a number of medication documentation errors.

This had resulted in medications not signed as having been administered. While the person in charge and regional manager gave assurances to the inspector that it was a documentation issue, audits had not been carried out with enough frequency to capture this information in a timely way to address medication management issues as they arose.

The person in charge and regional manager outlined more robust medication management training was scheduled for staff to attend in January 2015 and the medication audit tool would be enhanced to provide more information to ensure adequate assessment of practices.

In the interim, a system had been put in place whereby staff cross checked each other’s documentation of medication administration. However, it was not clearly outlined who would have oversight of this practice or if audits would be carried out more frequently.

While this Outcome is in compliance relating to the storage of medications and residents access to pharmacy, non compliances for medication management were found in Outcome 14 relating to auditing and Outcome 18 relating to documentation.

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):**
This was the centre’s first inspection by the Authority.

**Findings:**
The person in charge was well known to the residents. There was a warmth and evident rapport between her and residents. While there was clear evidence of residents' satisfaction with the person in charge of the centre, there were some improvements required to the governance and management systems in operation in the centre.

For example, the person in charge did not have direct oversight of residents' social care needs. These were directly supported by staff from other organisations for example, personal assistants.

There was limited scope in relation to the person in charge's management and supervision of staff working directly with residents as they were not always directly accountable to her and worked for other organisations. Management structures in the centre were clearly defined for staff working directly for the organisation but not as clear for staff that were not.

While audit systems were in place, they were not cohesively filed together and updated systematically to ensure monitoring and evaluation of the quality of care practices were maintained to a high standard. For example, the person in charge had not been timely informed of a notifiable injury to a resident and therefore, although she submitted the notification once informed, it had been submitted outside of the required timeframe. This indicated clinical care audits were not adequately maintained and communicated effectively.

Organisational auditing mechanisms required enhancement to ensure they captured data that reflected accurately the quality of care practices in the centre. For example, medication management auditing required improvement. Some medication errors and omissions of documentation had not been captured adequately on the audit tool in use.

While residents' social care, employment and personal network needs were supported, the person in charge did not have oversight of these services.
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):
This was the centre’s first inspection by the Authority.

Findings:
Of the sample of staff files reviewed they were found to contain most of the documents as required by 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, from the sample of four files reviewed, two staff files did not contain two written references.

There were no staff files kept in the centre for residents’ personal assistants. There was no written confirmation that they had been vetting or information retained as per the regulations set out in Schedule 2. The person in charge and regional manager confirmed that personal assistants were employed by other agencies and would have been vetted by the organisation they worked for. However, there was no documented evidence to confirm this.

Whilst mandatory training was in place, including training for nursing and non nursing staff in the management of medication, there had been a number of medication documentation errors identified by the person in charge and regional manager prior to the inspection. It was recognised by management that medication management training needed revision to ensure it provided staff with the necessary skills to carry out safe practices.

All staff had received training in adult protection however; some staff had not received refresher training in adult protection since 2011. The training matrix for staff did not outline allocated refresher training due dates.

Not all staff working in the centre had received food safety training. Staff supporting residents sometimes assisted or prepared their meals.

A number of residents in the centre had difficulty with swallowing or a diagnosis of epilepsy. Not all staff had received training in first aid or emergency epileptic seizure
Some residents in the centre had healthcare needs requiring nursing care. There was no nurse allocated to night duty. Nurse provision for the centre was 10 hours per week. This was not sufficient to address the healthcare needs of residents. These hours were not spaced across the week but for two five-hour days and no cover at weekends. There was a risk that residents’ health care needs may not be adequately met. Residents’ personal assistants did not necessarily have health care qualifications that would help them to recognise early signs of the development of pressure ulcers for example.

The overall resourcing of staff for the centre was not adequate and the centre was heavily reliant on residents’ personal assistants carrying out their social care and sometimes intimate care interventions. It was unclear where the lines of supervision and accountability were in order to ensure residents received care as per their intimate care plans or SALT recommendations.

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):
This was the centre’s first inspection by the Authority.

Findings:
Some of the operational policies required by Schedule 5 are not maintained for example, there was no visitor policy in place.

There had been a number of medication documentation errors. This had resulted in medications not signed as having been administered

Judgment:
Non Compliant - Moderate
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ann-Marie O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<td>29 October 2014</td>
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<td>Date of response:</td>
<td>9 December 2014</td>
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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:

Care was provided in a manner that respected residents' privacy, but improvements were necessary to the environment to ensure that each resident's personal and living space was respected by external users and visitors to the centre.

Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 09 (3) you are required to: Ensure that each resident’s privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
A risk assessment to be carried out by the Service Manager (in conjunction with Cheshire Irelands Risk Management/ Health & Safety Co-ordinator) in respect of visitors to the building by 15th December 2014.

Based on the outcome of this risk assessment, environmental control measures will be implemented to reduce / eliminate any risks or hazards identified.

Service Manager to consult with residents on acceptable control measures within the building, whilst not compromising residents ease of movement. Agreed actions to be implemented by 31st January 2015.

Service Manager to provide signage identifying private residential areas – completed.

Service Manager to provide updated information to any groups using the centre, informing them of restricted areas. 15th December 2015

**Proposed Timescale:** 31/01/2015

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**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:**
Personal plans on site had a health focus and did not provide adequate information on residents’ specific social, educational and employment needs. Social care plans were not maintained in the personal plans.

**Action Required:**
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
All residents will undergo a comprehensive social care needs assessment by the nursing team and trained local staff. A personal plan identifying social support requirements will be completed for each resident by 31st May 2015.

**Proposed Timescale:** 31/05/2015
### 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:

The risk management policy did not include all the measures and actions in place to control accidental injury to residents, visitors or staff for the risk identified during the inspection.

**Action Required:**

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Cheshire Ireland's National Risk Manager to review current risk management policy to ensure it includes all the measures & Actions in place to control accidental injury to residents, visitors or staff for the risk identified during the inspection.

**Proposed Timescale:** 01/02/2015

#### Theme: Effective Services

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

Adequate precautions against the risk of fire had not been ensured for residents that smoked and where adjacent to flammable products.

**Action Required:**

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

An updated risk assessment has been completed by the Service Manager Relating to Fire Safety for a Resident who smokes. Identified control measures are being implemented to reduce risk. Implementation of all control measures will be completed by 1st January 2015, including provision of fire retardant materials.

**Proposed Timescale:** 01/01/2015

### Outcome 08: Safeguarding and Safety

#### Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Assessment, safeguarding and quality assurance of restrictive procedures did not follow best practice guidance.

Restraint was not assessed in accordance with national policy and evidence based practice. There were numerous restraint interventions documented on one risk assessment sheet. This meant the identified risk was not clearly indicated.

Measures in place to control the risk of entrapment in bed rails, posed a risk of suffocation.

**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:**
An individual risk assessment regarding each resident to be carried out (with the support of the Clinical Services Support Team). Each restraint to be risk assessed on a separate risk assessment form, Restraints Policy to be ensure it is being fully implemented.

An updated person centred risk assessment to be carried out with one individual who has requested a control measure which increases risk of suffocation.

**Proposed Timescale:** 31/03/2015

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence based nurse care planning and documentation needed improvement. Fluid input/output charts were not filled comprehensively or totalled at the end of each day to assess residents’ hydration or risk of dehydration.

Nursing care plans were not in place for resident at risk of recurrent infection and pressure areas.

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

**Please state the actions you have taken or are planning to take:**
A specific care plan for the management of hydration has been developed for the individual.

Information session for staff to be completed on appropriate management of hydration and documentation of same, for residents who require it.
Staff nurse to monitor the recording & documentation of fluid balance charts weekly.

**Proposed Timescale:** 31/01/2015

### 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:**
Management and supervision systems for staff working with residents required review. This was necessary to enhance the person in charge's oversight and supervision of all service supports provided to residents to ensure they were safe, appropriate to residents' needs, consistent and effectively monitored.

**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:**
The service manager will schedule documented quarterly meetings with external providers to discuss residents social support needs and responses. The first meeting will be scheduled before 31st January 2015.

The Registered Provider will develop a proposal in partnership with HSE, for Cheshire Ireland to undertake the planning and provision of additional social supports to residents of Galway Cheshire. 31st December 2015

**Proposed Timescale:** 31/01/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Audits of care practices and supports in the centre required improvement to ensure they captured data that reflected the quality of support and care given to residents and informed the person in charge and provider of where improvements were necessary.

**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:**
The Clinical Service Support Team will commence the roll out of revised medication management audits in 1st quarter of 2015. Incremental roll out of further audits as part of a standard clinical audit program across areas of Cheshire Irelands Restraints Policy, Personal Planning Process and Infection Control Procedures will be implemented in
quarters 2, 3, and 4 respectively.

All nursing care support and management staff will be trained to audit the operation of each of these Cheshire Ireland's organisational policies & procedures sequentially. Results will be returned to Regional Clinical Education Facilitator for analysis and outcomes will be returned to the service and monitored nationally with target supports and intervention provided by both internal and external supports as indicated.

**Proposed Timescale:** 31/03/2015

### Outcome 17: Workforce

**Theme:** Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number and skill mix of staff were insufficient to meet the needs of residents.

**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:**
The registered provider is reviewing the skill mix and qualifications of the staff at present in relation to the dependency levels and complexity of health care needs of the residents.

There is an identified need for additional nursing hours and days available to Cheshire Ireland residents.

**Proposed Timescale:** 31/03/2015

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff working for the organisation had documents set out as per Schedule 2.

**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 staff files (utilising the requirements outlined in Schedule 2) to be carried out by the West / Northwest Administrator.
A gap analysis to be documented identifying all outstanding documents not contained within staff files and these documents to be sourced 1st March
**Proposed Timescale:** 01/03/2015  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Volunteers/personal assistants did not have a staff file maintained in the centre with written confirmation that they had received vetting and documents as set out in Schedule 2 had been obtained by their employer.

**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:**  
A memorandum of understanding will be developed and agreed between Cheshire Ireland and external providers who provide social supports to Cheshire Residents covering staffing records.

The service manager will schedule documented quarterly meetings with external providers to discuss residents social support needs and responses. First meeting before 31st January 2015.

**Proposed Timescale:** 31/01/2015  
**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was insufficient nursing care provision for residents living in the centre.

**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:**  
The registered provider is reviewing the skill mix & qualifications of the staff at present in relation to the dependency levels and complexity of health care needs of the residents. There is an identified need for additional nursing hours and days available to Cheshire Ireland residents.

**Proposed Timescale:** 31/03/2015  
**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Continuity of nursing care and support for residents was not adequate.

**Action Required:**
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

**Please state the actions you have taken or are planning to take:**
The registered provider is reviewing the skill mix & qualifications of the staff at present in relation to the dependency levels and complexity of health care needs of the residents.

There is an identified need for additional nursing hours and days available to Cheshire Ireland residents.

**Proposed Timescale:** 31/03/2015

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff required training in relation to the particular needs of residents, for example first aid, food safety and emergency management of epileptic seizures.

**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 review of all staff training will be carried out by the Service Manager and a training schedule developed for 2015 which addresses any gaps. This will be completed by 31st December 2014.

Food Safety to be completed for identified staff by 31st January 2015.

AED training to be completed for identified staff by 31st March 2015.

**Proposed Timescale:** 31/03/2015

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no written documentation of supervision of personal assistants that supported residents.

**Action Required:**
Under Regulation 30 (b) you are required to: Provide supervision and support for
volunteers working in the designated centre.

**Please state the actions you have taken or are planning to take:**
As these individuals are not volunteers but in the employ of other organisations, Cheshire Ireland cannot provide performance management to these individuals. However formalised structured communication and correspondence between the Cheshire Ireland Service Manager and these identified organisations will be commenced as follows.

The Service Manager will schedule documented quarterly meetings with external providers to discuss residents social support needs & responses. The first meeting will be scheduled before 31st January 2015.

**Proposed Timescale:** 31/01/2015

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**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some of the operational policies required by Schedule 5 are not maintained for example, there was no visitor policy in place.

**Action Required:**
Under Regulation 04 (2) you are required to: Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

**Please state the actions you have taken or are planning to take:**
A gap analysis to be carried out to identify any policy gaps (as outlined in Schedule 5).

Any policies not in existence to be addressed by the relevant departments within Cheshire Ireland.

A visitor policy will be developed by 31st March 2015 for the national organisation.

**Proposed Timescale:** 01/09/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff were aware of the centre’s policies but did not always reflect them in practice. There had been a number of medication documentation errors. This had resulted in medications not signed as having been administered.

**Action Required:**
Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

**Please state the actions you have taken or are planning to take:**
The Clinical Service Support Team will commence the roll out of revised medication management audits by 28.02.15. All nursing, care support and management staff will be trained to audit the operation of each of these Cheshire Ireland's organisational policies and procedures sequentially.

Incremental roll out of further audits as part of a standard clinical audit program across areas of Cheshire Ireland's Restraints Policy, Personal Planning Process and Infection Control Procedures will be implemented in Quarters 2,3 and 4 sequentially.

**Proposed Timescale:** 28/02/2015