

**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-0003445
Centre county:	Galway
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	Florence Farrelly (Day 2)
Type of inspection	Announced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	1

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
08 July 2015 11:00	08 July 2015 20:00
09 July 2015 10:00	09 July 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 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management

Summary of findings from this inspection

This report sets out the findings of an inspection carried out in Galway Cheshire House. The inspection originally was intended to be a registration inspection however, given the serious risks identified by the inspector during the first day of the inspection in Health & Safety & Risk Management, Rights, Dignity & Consultation and Safeguarding & Safety the decision was taken to focus on a core outcomes relating to risk. The inspector was joined by a second inspector on day two of the inspection.

Residents spoken with were complementary of some staff working in the centre stating they were kind, caring and patient with them. However, residents were critical of a small number of staff working in the centre. They told inspectors that those staff were disrespectful to them. Residents had logged complaints that staff took a very long time to come to them when they called for assistance. However, those documented complaints did not indicate what measures had been put in place to address the residents' concerns.

On the first day of inspection an inspector spoke with a resident who was critical of the service they were receiving. The inspector found that procedures in place to protect this resident while smoking were unsafe and placed the resident at risk of burns. An immediate action was issued following the inspection in relation to Health & Safety & Risk Management and also Safeguarding & Safety.

Residents' rights, dignity and consultation were not adequately upheld in the centre. Complaints were not managed in a robust way and some residents were frustrated that their grievances were not being addressed. Such was some residents' frustration that on day two of the inspection one resident was refusing to eat or take their medication, another resident told inspectors they would begin to refuse to get out of bed until their issue was addressed. Both residents had significant physical disabilities which would be impacted upon should they refuse to participate in activities of daily living.

Of the six Outcomes reviewed on inspection, four received a Major non compliance and two received Moderate non compliance. The findings of this inspection are set out in this report with an action plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Not all aspects of this Outcome were reviewed during this inspection. Of those that were a number of non compliances were found. These related to inadequate complaints management, policies and procedures. A lack of meaningful and documented consultation of residents' wishes and preferences in relation to the running of the centre and the service they received.

Residents spoken with during the inspection informed both inspectors at different times that they had been treated in a disrespectful manner by a small number of staff working in the centre. A number of non compliances relating to this are also given in Outcome 8; Safeguarding and Safety.

On the first day of inspection an inspector met with a resident who was critical of the service they were receiving and had told the inspector about poor practices in relation to how they were supported to smoke, this is further outlined in Outcome 7; Health & Safety & Risk Management and also Outcome 8; Safeguarding & Safety. The inspector was concerned at what the resident told them and brought it to the attention of the person in charge and quality manager. Given the serious nature of the risk the resident had experienced an immediate action was issued subsequent to the inspection . On the second day of inspection, the inspector met with the resident who stated 'they know I reported them', while the resident did not elaborate further, the inspector was not satisfied that residents were not adversely affected by making a complaint in the centre.

The organisation had a policy with associated procedures in relation to the management of complaints. However, there were a number of non compliances found in relation to

complaints management. The complaints procedure for the centre was not centre specific. It did not outline who the nominated person was for the centre or who the nominated person, independent of the person nominated to deal with complaints were.

Advocacy information was available to residents in the form of leaflets located on the notice board. However, there was no evidence that this was a meaningful option for residents or that residents used advocacy services. For example, on the second day of inspection a resident expressed to inspectors their dissatisfaction and distress at being supported daily by personal assistants employed by an agency other than Cheshire Ireland.

According to the resident, they had experienced emotional upset, distress and frustration every morning for the last 10 months while they were supported by a care provision agency that they did not trust or want to provide their care anymore. They had lodged their request to be supported by Cheshire Ireland workers with an external agent with responsibility to address this issue. However, at the time of inspection the resident told inspectors they were extremely dissatisfied with the lack of response and information they had received in relation to their request to change care provision. The person in charge and provider had a responsibility to ensure residents had access to advocacy services for the purposes of making a complaint. The resident confirmed they did not have an advocate that could review the issue on their behalf.

The ineffective complaints management systems for the centre did not only impact on the aforementioned resident, there were a number of other non compliances in relation to complaints that negatively impacted on residents. For example the complaints policy and leaflets to log a complaint were pinned to a notice board the located on the corridor to residents' apartments. However, they were not accessible to most residents in the centre. The profile of residents living in the centre included those with significant physical disabilities whereby they used assistive mobility devices in some cases, in other cases they were unable to move their limbs or leave their apartments independently. The provider had not ensured there was a complaints procedure was in an accessible format for residents living in the centre. The procedure was not appropriate to the needs of residents in line with the nature of each resident's disability.

At the time of inspection two complaints lodged by residents expressed their dissatisfaction with how long it took staff to come to their assistance when they called. While the complaints had been documented there was no further information documented of how the complaint was addressed or actions taken.

A residents' committee meeting folder was reviewed by the inspector. However, it did not contain any minutes of meetings as no residents had attended any of the scheduled meeting dates. The inspector was informed that this was a long standing pattern for residents not to show up and while there was no regulatory requirement for residents to attend a gathering or group meeting to garner their feedback on the service, there was a requirement that residents' received adequate consultation.

Residents confirmed to the inspector they spoke regularly to the person in charge and consulted with her however, there was little documented evidence of this consultation and this required review given the number of complaints and expressions of

dissatisfaction by residents. Such was some residents' dissatisfaction and frustration that on day two of the inspection, a resident was refusing to eat or take their medications in protest, while another resident told inspectors they would begin to refuse to get out of bed if their issue wasn't dealt with soon.

There were inadequate privacy measures on the windows in residents' apartments. Some apartments were overlooked by houses in the estate in which the centre was located. Their apartments could be seen from the first floor windows of those houses, therefore privacy measures on residents' windows were necessary. The inspector was not satisfied that resident's privacy was safeguarded in some apartments, some residents could not independently move or pull closed curtains or blinds on windows and this required review.

All residents spoken with identified some members of staff working in the centre as being very caring and kind. However, residents were not always treated with respect by a small number of staff working in the centre. Inspectors were told by a number of residents that certain staff were disrespectful to them telling inspectors, 'they are not nice to me', 'I am treated like a baby', 'they say 'what do you want', when I call for assistance'. A resident recalled a time when they asked for their bed linen to be changed and heard one staff tell another, 'don't do it'. As a result inspectors were very concerned about the systems in place to supervise staff and monitor the quality and safety of care provided to residents.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

While some improvements had been made since the previous monitoring inspection October 2014, there were significant risks identified in this outcome some of which required immediate action to address. This related to risk of injury from smoking.

Systems were in place on the prevention and management of fire. However, improvements were required. Fire fighting equipment was provided and had been serviced in April 2015 The fire alarm system had been serviced on a quarterly basis. Fire exits were unobstructed and daily checks were completed by staff.

Fire drills had occurred in February and June 2015 but these had occurred during fire

training and there had been no drills outside of these times to ensure staff could carry out a response to a fire without a qualified instructor. There had also been no night time drills. This required review and an immediate action was issued for this to be addressed.

There were no emergency lights in residents' apartments which would direct them to an exit in the event of a fire.

The inspector requested to see the fire compliance certificate for the centre to ascertain how fire compliant the building was. It was confirmed to her that the building was compartmentalised however, the attic was not. This meant if a fire broke out in one part of the building and entered the attic it could spread to other areas in spite of other areas being compartmentalised, this required review.

During the course of the inspection, a resident spoke with the inspector and informed her they smoked and a fire blanket was used to protect them while they smoked. The resident had a neurological condition which meant they could not move their arms and had limited movement of other parts of their body. They informed the inspector that staff put the fire blanket around them, lit a cigarette, put it in their mouth and walked out of the room leaving them unsupervised.

They informed the inspector that the fire blanket used to protect them had been replaced with a new one before the inspection and the other blanket had lots of burn marks where cigarettes had fallen onto it. This was further confirmed by cigarette smoking risk assessments for the resident which documented the procedure in which staff put the blanket around the resident, light the cigarette, put it in the resident's mouth and walk out of the apartment.

The inspector was concerned at this practice as it posed a significant risk to the resident. The inspector spoke with the person in charge and quality manager in relation to what the resident had informed them and requested to see the old fire blanket. On day one it was unavailable. However, on day two it was available. It had multiple cigarette burn marks all over it. The inspector issued a number of immediate actions in relation to this practice to ensure the resident was no longer at risk.

A risk management policy was in place and contained all the matters as set out in the regulations. A health and safety statement was also in place but out of date since 2008.

A newly appointed health and safety officer (HSO) had recently carried out a comprehensive health and safety assessment of the premises two days prior to the inspection. There were a number of actions which required addressing as a result of the audit. The inspector spoke with the HSO about their plans to address the risks identified and was satisfied their plan would be comprehensive and address issues if implemented by the provider.

An accident/incident report was completed for all incidents and these were reported to the quality manager who produced an audit report with regard to these. The inspector noted a significant number of medication errors had been recorded. This is further reviewed in Outcome 12: Medication Management.

Infection control procedures were in place, there were adequate hand washing facilities and alcohol hand gels available. However, there had been two ant infestations in two different apartments which had been recorded on the incident/accident system. These had been addressed by the maintenance personnel however, there were no proactive pest control systems in place for the centre.

All residents spoken with during the course of the inspection highlighted their concerns in relation to an aspect of security of their apartments. This worried them and the details of this were discussed at the feedback meeting. This risk had been identified by the HSO during their audit. The inspector reviewed this issue during visits to individual apartments and found that residents' concerns were founded. However the provider had failed to respond to this issue.

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):

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

Findings:

The inspector had a number of concerns in relation to safeguarding and safety of residents in this centre. This was in part due to the practices supporting some residents to smoke which put them at serious risk of fire related injuries and also in relation to residents saying a small number of staff were disrespectful to them.

As mentioned in Outcome 7 an immediate action was given in relation to risks identified for a resident who smoked. A further immediate action was given by inspectors to ensure the provider investigated this practice under safeguarding also. Another immediate action was also given under safeguarding & safety in relation to residents' allegations that a small number of staff were disrespectful to them.

Having spoken to a number of staff the inspectors were not assured all staff working in the centre had an appropriate understanding of what constituted abuse. This required review.

As highlighted under outcome 1 the provider had failed to appropriately respond to complaints and issues of concern raised by residents. Inspectors found that this could compromise the safeguarding of residents.

Judgment:

Non Compliant - Major

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):

Findings:

Not all aspects of this Outcome were reviewed on this inspection.

The inspector observed where food hygiene and safety was not adequately carried out. A tray of frozen mince meat was left to thaw out on a counter top in one resident's kitchen. When the inspector asked the resident had they left it there they said they had not. They also informed the inspector they didn't know anything about food hygiene or safety.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Not all aspects of this Outcome were reviewed on this inspection.

As outlined in Outcome 7, there had been a number of medication errors logged in the incident and accident log book. From interviewing staff and reviewing the incidents logged it was apparent there were issues with the updating of medication administration charts to reflect medication changes made by a resident's GP, for example. Therefore, there had been some instances whereby residents had not received medication they had been prescribed. There had also been occasions where tablets had been found in residents' apartments which had not been administered to the resident. Medication Management systems in the centre required review to mitigate the risk of medication errors which would ultimately result in negative outcomes for residents in the centre.

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):

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

Findings:

The Inspector found the current governance and management systems in place required review. The post of person in charge of the centre was full time and met the requirements of the Regulations. The person in charge was supported by a regional services manager who reports to the provider nominee. Management structures in the centre were clearly defined for staff working directly for the organisation but were not clear for the staff that were not.

There was limited scope in relation to the person in charges' management and supervision of staff working directly with residents as some staff working with residents were not directly accountable to her as they worked for other organisations. A memorandum of understanding between Galway Cheshire and one of the external organisations who provide supports for some residents in the centre, had been drafted in February 2015. It sets out that the Cheshire Ireland Service Manager Galway and the other organisation's Assisted Living Service Coordinator will meet each quarter to review service provision for those people who receive shared services. Other scheduled activities include, the Cheshire Ireland Service Manager facilitated to attend part of the other organisation's team meetings which would provide an opportunity to review /

inform the Cheshire Ireland Care Plan.

While this was drafted to bring about improvement in governance and management systems for workers not employed by Galway Cheshire, it did not address governance issues and instead set out more robust communication systems between both agencies. Residents' social care, employment and integration into the wider community were not adequately supported, as the person in charge did not have management responsibility for external organisation workers.

There was no management presence in the centre from Friday evening until Monday morning. Residents spoken with told an inspector the centre ran as normal when the person in charge was working but not as good when she was not there. The person in charge was not adequately supported by the governance structures for the centre. In the absence of the person in charge there were inadequate supervision and management systems in place.

The provider had yet to complete a report of the review of the safety and quality of the service as required by Regulations. While a medication audit was carried out, some other audits reviewed were not centre specific but regional and it was difficult to ascertain what centre incidents had taken place in. There was no system of reviewing the quality and safety of the service provided to residents in the designated centre. Inspectors were informed the provider had visited the centre on a number of occasions in the past year. However, there was no evidence of a report on the visits to the centre.

Inspectors spoke to staff and found that they could not bring concerns to management easily. Improvement was required to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents. As highlighted in outcome 1, the provider did not have adequate systems in place to supervise staff and to monitor the quality and safety of care.

Judgment:

Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ann-Marie O'Neill

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-0003445
Date of Inspection:	08 July 2015
Date of response:	21 August 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 were inadequate privacy measures on the windows in residents' apartments.

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

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)Quotations have been obtained to install plastic / perspex cover on each window located near the door of every apartment. This work will be actioned week commencing 24th August 2015.

b)Blinds & Curtains have been installed in Apartment 1 to address the privacy issues identified during the inspection

c)A budget for Blinds & Curtains has been allocated and these will be purchased and put up in consultation with individual residents by 25 September 2015.

a) 24th August 2015 b) completed c) 25th September 2015 Responsible Individual(s): Person in Charge / Health & Safety Officer

Proposed Timescale: 25/09/2015

Theme: Individualised Supports and Care

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

Residents were not always treated with respect by a small number of staff working in the centre. Inspectors were told by a number of residents that certain staff were disrespectful to them.

Action Required:

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

a)Preliminary enquiries (under Cheshire Irelands Adult Protection Framework) involving 1 staff member identified by residents as behaving in a disrespectful manner were carried out by the Regional Manager. This staff member has been suspended with pay and without prejudice pending the outcome of formal investigations being carried out into the allegations. These investigations are being carried out by an external third party.

b)The Person in Charge and Registered Provider have met with both Service Users and staff as a group and individually and advised them to raise any concerns regarding any instances where they observe individuals being treated in manner with is not in line with Cheshire Irelands ethos and values and not in line with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

c)A further staff member has subsequently been suspended with pay and without prejudice pending the outcome of a further formal investigation which has been established into further allegations.

d) Monthly one-to-one meetings will be held by the Service Manager with the residents and the group meetings to consult with the residents will be re-invigorated.

e) The communal room will be done up to become an attractive, comfortable space for residents to meet, both formally and informally.

f) The Regional Manager will make time to meet formally and informally with residents to ensure there is another person available to listen to feedback. Structured meetings with residents will take place on a quarterly basis.

g) Adult Protection Sessions on the rights of residents to be safe and protected in the centre will be held to make them clear of their rights and the responsibility of the Provider.

h) Further sessions on safeguarding and supporting residents will be held with staff during the month of September.

i) Each resident has been given information about the availability of local advocacy services and how to access them. This information can also be i) provided to them in written formats accessible to their individual needs.

a) investigation to be completed by 15th September 2015 b) 21st August 2015 c) 21st August 2015 d) 31st August 2015 and ongoing e) 30th November 2015 f) September 30th 2015 and ongoing g) 18th September 2015 h) 18th September 2015 i) 21st August 2015

Responsible Individuals: Person in Charge, Regional Manager, Registered Provider, Cheshire Irelands Human Resources Department

Proposed Timescale: 18/09/2015

Theme: Individualised Supports and Care

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

Residents confirmed to the inspector they spoke regularly to the person in charge and consulted with her, however there was little documented evidence of this consultation and this required review given the number of complaints and expressions of dissatisfaction by residents to inspectors during the inspection.

Action Required:

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

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

a) Since the 9 July all residents have been individually met on three occasions by the Person in Charge to consult on their views of the service and allow any issues of concern to be raised. These meetings are documented and will continue on a formal

basis monthly as part of service user consultation.

b) Residents will be encouraged to attend monthly residents' meetings and consulted about the design and content of these meetings. The first meeting will be held on 31st August 2015. Refreshments will be provided and the communal room will be re-designated and made more attractive and comfortable.

c) The Regional Manager will meet all residents on a quarterly basis with initial meetings held in September 2015. Meetings will be informal but structured with documentation available.

d) Formal Service evaluation meetings will be held bi-annually with a provider designate external to the local service. The first evaluation and annual review of service will be completed by 31st October 2015.

e) The complaints database will be reviewed by the Regional Manager on a monthly basis as part of the supervision of the Service Manager to ensure complaints are being addressed and the resident is satisfied that they have been appropriately addressed.

f) The Provider will review complaints trends in Galway Cheshire on a quarterly basis.

a) completed and on-going b) 31st August 2015 c) 30th September 2015 d) 31st October 2015 e) Immediate and on-going f) immediate and ongoing
Responsible Individual(s): Person in Charge/ Regional Manager/Quality Officer

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

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

The provider had not ensured there was a complaints procedure in an accessible format for residents living in the centre.

Action Required:

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

a) An updated and easy to read poster has been displayed in the centre outlining the Cheshire complaints procedure and who to contact to raise concerns with. This will be reviewed with each resident to ensure their understanding of the process and who to contact.

b) The Person in Charge will hold information sessions with residents ensuring their understanding the complaints process and how to access it and who to raise concerns with.

c) The National Learning and Development Manager in conjunction with the Service Quality Officer are developing an on-line video session outlining the complaints procedure and providing guidance / support for Service Users and family members about making complaints. This on line video will be available on the Cheshire Ireland website to ensure the procedure is available in versions appropriate to meet the needs of all individuals. It will delivered to residents during a residents meeting.
a) 21st August 2015 b) 31st August 2015 c) 31st October Responsible Individual(s): Person in Charge . National Learning and Development Manager & Service Quality Officer

Proposed Timescale: 31/10/2015

Theme: Individualised Supports and Care

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

The complaints procedure for the centre was not prominently displayed for residents.

Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

An updated and easy to read poster has been displayed and distributed in the centre outlining the Cheshire complaints procedure and who to contact to raise concerns with. This will be reviewed with each resident to ensure their understanding of the process and who to contact.

Responsible Individual(s): Person in Charge.

Proposed Timescale: 21/08/2015

Theme: Individualised Supports and Care

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

The person in charge and provider had a responsibility to ensure residents had access to advocacy services for the purposes of making a complaint. A resident confirmed they did not have an advocate that could review their issue on their behalf.

Action Required:

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

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

a) All Service Users have been advised of their right to access an advocate. Details of advocacy services within the Galway area will be discussed with Service Users as per

action on regulation 34 (1) above. Local Advocacy Service details are available on the notice board. The Person in Charge has advised Service users that she will support them to access and advocate at any time, should they require to do so.

b) the National Advocacy service has been invited to attend a residents meeting
Responsible Individual(s): Person in Charge

Proposed Timescale: 21/08/2015

Theme: Individualised Supports and Care

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

On the second day of inspection, the inspector met with the resident, they told her, 'they know I reported them', while they didn't elaborate further, the inspector was not satisfied that residents were not adversely affected by making a complaint in the centre.

Action Required:

Under Regulation 34 (4) you are required to: Ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

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

a) Since 9th July all service users have been individually met on three occasions by the Person in Charge to consult on their views of the service and allow any issues of concern to be raised. These meetings are documented and will continue on a formal basis as part of service user consultation

b) Adult Protection sessions will be held with residents, Revised adult protection training will be delivered to all staff. Individual resident & staff support sessions will be held by person in charge post-delivery.

c) As a safeguarding measure to date two staff members have been suspended without prejudice pending the completion of full formal investigations. Findings of the investigation will be acted upon by the Provider

d) During staff supervision sessions the Person in Charge will emphasise the adult protection policy and zero tolerance of abuse in all forms.

a) 21/08/2015 and ongoing b) 18th September 2015. C) 21/08/2015 d) monthly
Responsible Individual(s) Person in Charge, Regional Manager, National Learning and Development Manager.

Proposed Timescale: 18/09/2015

Theme: Individualised Supports and Care

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

the following respect:

The complaints procedure for the centre was not centre specific. It did not outline who the nominated person was for the centre.

Action Required:

Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

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

a) An updated and easy to read poster has been displayed in the centre outlining the Cheshire complaints procedure and who the nominated persons are . This will be reviewed with each resident to ensure their understanding of the process and who to contact.

b) The Service Manager is the local officer designated responsibility for dealing with complaints. In the case of a complaint against the Service Manager, these will be dealt with by the Regional Manager on behalf of the Provider. Contact details for a representative of the provider (Cheshire Quality Officer) external to the local service have also been provided

Responsible Individual(s): Person in Charge

Proposed Timescale: 21/08/2015

Theme: Individualised Supports and Care

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

The complaints procedure for the centre was not centre specific. It did not outline who the nominated person, independent of the person nominated to deal with complaints were.

Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

a) An updated and easy to read poster has been displayed in the centre outlining the Cheshire complaints procedure and who the nominated persons, external to the Service, are. Information on contact details for the National Advocacy Service will be prominently displayed with in the centre This will be reviewed with each resident to ensure their understanding of the process and who to contact.

b) The Service Manager is the local officer designated responsibility for dealing with complaints. In the case of a complaint against the Service Manager, these will be dealt with by the Regional Manager on behalf of the Provider. Contact details for a representative of the provider (Cheshire Quality Officer) external to the local service

have also been provided
Responsible Individual(s): Person in Charge

Proposed Timescale: 21/08/2015

Theme: Individualised Supports and Care

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

While complaints had been documented there was no further information documentation for some of how the complaint was addressed or actions taken.

Action Required:

Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

a) Hard copies of complaints were available in complaints file on the day of inspection, follow up and outcome to complaints was available on the Complaints database. Hardcopy follow-up documentation is now stored in the complaints file, which is held in the Person in Charge office.

b) The online complaints database contains a section entitled "outcome" where information regarding the management of the complaint and how it was addressed is inputted by the Person in Charge. The database also contains a section where information regarding the Service Users satisfaction with the management and outcome of the complaint is logged. This database will be reviewed in a monthly basis by the Regional Manager to ensure complaints are being addressed and managed in a thorough manner.

Persons Responsible: Person in Charge, Regional Manager, Service Quality Officer.

Proposed Timescale: 21/08/2015

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:

A health and safety statement was also in place but out of date since 2008.

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:

a)The Health and Safety statement has been updated and implemented by the Health and Safety Officer and signed off by the Registered Provider and Person in Charge.
Responsible Individual(s): Person in Charge / Health and Safety Officer

Proposed Timescale: 21/08/2015

Theme: Effective Services

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

There had been two ant infestations in two different apartments which had been recorded on the incident/accident system. These had been addressed by the maintenance personnel; however, there were no pest control systems in place for the centre.

Risk assessments completed for one resident who smoked recommended unsafe procedures and required immediate review.

All residents spoken with during the course of the inspection highlighted their concerns in relation to a security issue in their apartments.

Action Required:

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

• In relation to the ant infestations:

a) A Pest Control company has been appointed. The name of the company is Rentokil. A contract has been put in place and the contractor will visit the Centre quarterly and or when required.

b) In relation to the resident who smokes:

• A fire risk Assessment was conducted in the apartment.

• Curtains had previously been sprayed with a fire resistant spray.

• A unit has been purchased for the resident's paints and other flammable materials. This in turn will house all flammable materials in one area.

• Turpentine when delivered to the Centre is stored in the chemical store area. A separate unit was purchased for the small amount of turpentine. A small volume of turpentine is decanted into a flask that the resident uses.

• A sand pit was also purchased and is located near the paints and other painting apparatus etc.

• The area is cleaned on an on-going basis and care support workers have been informed to ensure good housekeeping standards are in place at all times.

• Scheduled building works will further improve fire safety within the building, a contractor has been appointed and the work is scheduled to begin week commencing 31st August 2015 with planned completion by 30th September 2015.

c) In relation to a security issue in the apartments.

- Additional safeguards are being attached to residents windows until all building works are completed. To be completed by 31st August 2015.
- Window restrictors will be placed on all apartment windows to address security concerns raised.
- Scheduled building works will further improve security within the building, a contractor has been appointed and the work is scheduled to begin week commencing 31st August 2015 to be completed by 30th September

a) 21st August 2015 b) 21st August 2015 c) 30th September 2015

Responsible Individual(s): Provider, Regional Manager Person in Charge, Health and Safety Officer.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

Fire drills had occurred in February and June 2015 but these had occurred during fire training and there had been no drills outside of these times to ensure staff could carry out a response to a fire without a qualified instructor. There had also been no night time drills. This required review.

Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

- Fire Drill has taken place evening :15.07.2015
 - Fire Drill has taken place Day: 27.07.2015
 - Fire Drill taken place night: 19.08.2015
 - Fire drills will occur on a monthly basis in future.
 - PEEPS will be updated where required following drills
- a) 21st August 2015 b) 21st August 2015 c) 21st August 2015 d) completed As above & On-going Responsible Individual(s): Person in Charge, Health and Safety Officer

Proposed Timescale: 21/08/2015

Theme: Effective Services

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

the following respect:

There were no emergency lights in residents' apartments which would direct them to an exit in the event of a fire.

Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

a) Emergency lighting is available throughout the common areas of the building. Emergency lighting to be installed in each apartment as part of the scheduled building works

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

The attic space of the centre was not compartmentalised. Therefore, there were inadequate fire containment systems in the centre.

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:

a) A fire risk assessment was conducted in July 2015 by FCC Fire Consultants. Donal O' Keeffe was the Fire Safety Consultant who conducted this work.

b) Following on from the findings and recommendations in FCC's fire consultancy report, three contractors were asked to come on site and review the Centre and submitted a schedule of works for fire safety issues along with quotations.

c) A contractor has been employed and the schedule of fire safety improvement works including attic compartmentalisation will commence in the week beginning 31st August 2015 to be completed by 30th September 2015.

a) 21st September 2015 b) 21st September 2015 c) 30th September 2015 Responsible Individual(s): , Health and Safety Officer, Provider Nominee, Regional Manager

Proposed Timescale: 30/09/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

the following respect:

Information received in relation to some staff did not provide assurances that residents' were adequately protected from abuse. The provider did not adequately respond to issues of concern raised residents.

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) Since 9th July all service users have been individually met on three occasions by the Person in Charge to consult on their views of the service and allow any issues of concern to be raised. These meetings are documented and will continue on a formal basis as part of service user consultation

b) The Regional Manager will meet all residents on a quarterly basis with. Initial meetings held in September 2015. Meetings will be informal but structured with documentation available.

c) Formal Service evaluation meetings will be held bi annually with a provider designate external to the local service. The first evaluation will be completed by 31st October 2015

d) Adult Protection sessions will be held with residents, Revised adult protection training will be delivered to all staff. Individual resident & staff support sessions will be held by person in charge post-delivery.

e) Preliminary enquiries (under Cheshire Irelands Adult Protection Framework) involving staff identified by residents were carried out. Two staff have been suspended with pay and without prejudice pending the outcome of formal investigations being carried out into the allegations. These investigations are being carried out by an external third party.

f) The Registered Provider met with all staff following the inspection and discussed the importance of ensuring Service Users feel safe and are protected from abuse and staff responsibilities around reporting any concerns they may have. The Registered Provider also met with Service Users (13th August 2015) to advise them of the importance of raising any concerns with the Person in Charge or any staff member who they trust.

g) Any allegations of abuse (either suspected or confirmed) are submitted to HIQA using an NF06 form and investigated thoroughly by the Person in Charge and senior members of Cheshire Ireland staff.

a) 21st August 2015 b) 30th September 2015 c) 31st October 2015 d) 30th September 2015 e) 15th September 2015 f) 21st August 2015 g) Completed and ongoing
Responsible Individual(s): Provider Nominee, Regional Manager, Person in Charge

Proposed Timescale:

Theme: Safe Services

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

A resident with a significant physical disability was left unsupervised on a number of occasions with a lit cigarette in their mouth. They could not remove the cigarette independently from their mouth or tip the ash from the cigarette. Multiple cigarette burns were found on the fire blanket which was placed around the resident when they smoked.

Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

a)The issue was identified and investigated by the Person in Charge who implemented a revised care plan and risk assessment. This ensures the resident is supported to smoke safely and incorporates a system which monitors it's effectiveness.

Responsible Person: Person in Charge

Proposed Timescale: 21/08/2015

Theme: Safe Services

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

The inspectors were not assured all staff working in the centre had an appropriate understanding of what constituted abuse. This required review.

Action Required:

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

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

a)The Registered Provider met with staff on 10th July following the inspection and discussed the importance of ensuring Service Users feel safe and are protected from abuse and staff responsibilities around reporting any concerns they may have.

b)Person in Charge and National Learning & Development manager will facilitate additional Adult Protection Training for all staff to ensure they have an appropriate understanding of what constitutes abuse. This will be delivered by an external agency and be reviewed with staff on an on-going basis during one to one supervision sessions.

a) 21st August b) 18th September 2015 Responsible Individual(s): Provider Nominee

Proposed Timescale: 18/09/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

The inspector observed where food hygiene and safety was not adequately carried out.

Action Required:

Under Regulation 18 (1) (b) you are required to: Ensure there is adequate provision, so far as reasonable and practicable, for residents to store food in hygienic conditions.

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

a) Food Safety training has been delivered to staff in August 2015. A small number of staff remain to be trained and this will be completed by 30th September 2015. Staff will be reminded to ensure safe practice in food handling during the next staff meeting.

b) The Health and Safety Officer has drafted a new Food Safety '3 Day Rule Policy' and a "Cooking Procedure" that will assist staff with food safety requirements.

c) Food safety awareness will be discussed with residents during the resident's meeting.

a) 30th September 2015 b) Policy / Procedure to be signed off by 15th September 2015. c) 31st August

Responsible Individual(s): Health and Safety Officer Person in Charge

Proposed Timescale: 15/09/2015

Outcome 12. Medication Management

Theme: Health and Development

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

Medication management systems in the centre were not robust. A number of medication errors had occurred and at times medications had been found in residents' bedrooms.

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:

a) Medication administration is reviewed at each handover. Outstanding medication to be administered will be assigned to particular staff.

b) Adverse Events Reports will be reviewed by Care Coordinator / Person in Charge to ensure any errors are identified and addressed.

c) A review of Medication Recording Sheets and corresponding Kardexes has been carried out by the Care Coordinator to address concerns.

d) A significant number of medication errors were specific to an individual service, medication management has been reviewed for this individual and a medication management care plan has been developed to address their specific requirements.

e) A quarterly medication audit is carried out and forwarded to the National Clinical Risk Manager.

f) Medication Errors are recorded in a Medication Only Adverse Book, this is reviewed by the Regional Clinical Education Facilitators with the Care Coordinator during regional clinical support sessions which are held every 6 weeks.

Proposed Timescale: 21/08/2015

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 structures in the centre were clearly defined for staff working directly for the organisation but were not clear for staff that were not.

Action Required:

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

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

a) A Memorandum of Understanding is in place between Cheshire Ireland and External Service Providers. This sets out agreement for consultation and quarterly review of care plans for individuals who receive shared services.

b) During monthly one to one meetings with residents Person in Charge will include a review of external support services, where provided. By agreement with the resident, issues or concerns where identified will be addressed with the external organisation by

the person in charge. Alternatively the Person in Charge will support the resident to direct their service with suggestions for improvements which could be made, according to resident's wishes.

a) 21st August 2015 b) 15th September and on-going 2015 Person Responsible: Person in Charge.

Proposed Timescale: 15/09/2015

Theme: Leadership, Governance and Management

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

There were inadequate supervision and management systems in place which had direct negative impacts on residents.

The person in charge was not adequately supported by the governance structures for the centre.

Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

a) The recently established Care co-ordinator position has been increased to 30 hours per week, provided over 7 days to increase management and governance supports in the centre.

b) The Care Co-ordinator will act as PPIM in conjunction with the Regional Manager and Person in Charge.

c) Structured supervision meetings will be held with all care staff on an 8 weekly basis with further supervision meetings as needed. Meetings will be documented

d) The Regional Manager will hold structured support and supervision Meetings with the Person in Charge on a monthly basis. Meetings will be documented

e) The Provider Nominee will hold structured support and supervision meeting with the Regional Manager on a monthly basis and documented.

a) 31st August 2015 b) 31st August 2015 c) 31st August and Ongoing d) 4th September and ongoing e) 18th September and ongoing Responsible Persons Registered Provider , Regional Manager Person in Charge

Proposed Timescale:

Theme: Leadership, Governance and Management

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

The provider had yet to complete a report of the review of the safety and quality of the

service as required by Regulations

Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

a) A review of the current quality audit system within Cheshire Ireland is underway. A working group has been appointed and the first meeting was held on 22nd July 2015. This group will ensure that a robust structure of audit will be in place within the organisation. A representative/s of the registered provider will carry out an unannounced visit by Cheshire Ireland Quality Team 31st October 2015 and produce an annual review report on their findings.

b) One of the Twice yearly unannounced visits will be a carried out by the provider by 30th September 2015 and a report on the standard of care prepared following these visit

c) A system of documented monthly unannounced visits will be implemented and documented by the Person in Charge and PPIM's .

a) 31st October 2015. Responsible b) 31st October 2015 c) 15th September 2015

Individual(s): National Working Group, Service Quality Team, Registered Provider

Proposed Timescale: 31/10/2015

Theme: Leadership, Governance and Management

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

There was no system of reviewing the quality and safety of the service provided to residents in the designated centre

Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

a) A review of the current quality audit system within Cheshire Ireland is underway. A working group has been appointed and the first meeting was held on 22nd July 2015. This group will ensure that a robust structure of audit will be in place within the organisation. A representative of the registered provider will carry out an unannounced visit by Cheshire Ireland Quality Team 31st October 2015.

b) Twice yearly unannounced visits will be a carried out and a report on the standard of care prepared following these visits. These audits will include meetings and conversations with Service users around their service and issues they may have or areas which they feel requires improvement.

c) A system of monthly unannounced visits will be implemented and documented by the Person in Charge and PPIM's .
Proposed Timescale:a) 31st October 2015. b) 31st October 2015 c) 15th September 2015 Responsible Individual(s):National Working Group, Service Quality Team, Registered Provider, Person in Charge,

Proposed Timescale: 31/10/2015

Theme: Leadership, Governance and Management

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

Improvement was required to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

a)The Registered Provider met with all staff following the inspection and discussed the importance of ensuring Service Users feel safe and are protected from abuse and staff responsibilities around reporting any concerns they may have.

b)The Person in Charge will hold one to one performance meetings with all staff on an 8 weekly basis to discuss their work performance and any issues / concerns / training requirements they may have.

c)Revised Adult Protection training session will be provided to all staff.

d)An information /training session on bullying and harassment in the workplace will be developed and delivered.

a) 21st August 2015 b) 11th September 2015 c) 18th September 2015 d) 30th September 2015

Responsible Individual(s): Registered Provider, National Learning and Development Manager, Regional Manager ,Person in Charge

Proposed Timescale: 30/09/2015