Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Waterford Cheshire
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	01 December 2021
Centre ID:	OSV-0003457
Fieldwork ID:	MON-0030379

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Waterford Cheshire was established in 2003 and provides accommodation and support in a purpose-built facility of self-contained apartments to adults with physical disabilities and neurological conditions. Individuals seeking to access services must be aged between 18 and 65 when they first arrive.
The service can accommodate 16 Service Users in total. Fourteen permanent residential apartments are available and two apartments are used to provide respite services. Most of the apartments have one bedroom, some have two bedrooms. All apartments have a kitchen/dining room and accessible bathroom.
Many of the people accessing the service have high physical support needs and the service endeavours to provide the supports required to enable each person to maintain the best possible health and to remain as independent as possible, for as long as possible. People living in the centre direct and participate in their own care.
The centre operates all year round and is staffed 24/7. A mix of nursing and support workers provide assistance to residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 1 December 2021	10:00hrs to 20:00hrs	Leslie Alcock	Lead
Wednesday 1 December 2021	10:00hrs to 20:00hrs	Conor Dennehy	Support

What residents told us and what inspectors observed

This was an unannounced inspection completed to assess the centre's ongoing compliance with regulations and standards. The inspection took place during the COVID-19 pandemic and therefore appropriate infection control measures were taken by the inspector and staff to ensure adherence to COVID-19 guidance for residential care facilities. This included the wearing of personal protective equipment (PPE) and maintaining a two metre distance at all times during the inspection day.

On arrival, inspectors went to the main door of the larger building of the designated centre. It was noted that a number of COVID-19 related signs were on display here including a notice from March 2020 indicating that visiting to the centre was prohibited. This door was locked at the time and inspectors were directed to a side entrance where a staff member took inspectors' temperature and performed some COVID-19 related checks. The designated centre was made up of a larger building with staff facilities and individual apartments for up to 10 residents while a further six apartments were located just outside this building. The larger building also contained other rooms and apartments which was were not part of the designated centre.

The inspectors spoke with the residents to determine their views of the service, observed where they lived, observed care practices, spoke with staff and reviewed the residents' documentation. This information was used to gain a sense of what it was like to live in the centre. At the outset of the inspection, inspectors received a tour of the larger building and the surrounding grounds. None of the residents' apartments were visited at this time but inspectors were shown a vacant apartment that was ordinarily used for respite. A water leak had been identified in this apartment which had damaged the flooring. Inspectors were informed that this water leak had been identified the previous day and was in the process of being rectified. During this walk around inspectors also noted, on the first floor of the larger building, a railing and a gate that was used to block two sets of stairs from the ground floor. This railing and gate were later seen to have been opened. During this inspection it was noted that Christmas decorations had been put up while cleaning was also being carried out. Art work from another resident was observed outside an office in the main building and it was communicated that this resident had an art exhibition the week of the inspection. It was explained that this resident's art work was chosen out of a couple of hundred applicants and that the resident was very excited about it.

As the day progressed, inspectors began to meet residents in their apartment at times residents requested. The inspectors met with 11 residents on the day of the inspection. While a number of residents were very complimentary about the service provided and described staff working in the centre as fantastic, that they generally came quickly when requested, that the ethos of independent living suited them and the location was convenient, a number of residents complained about staffing levels and advised some staff had a bad attitude and were not person-centred in their

approach with them. For instance; it was highlighted to the inspectors that sometimes a staff member who was supposed to be working with a resident would cancel at short notice without being replaced and they were not always informed about who would be working with them. It was also mentioned that the provider was working with the resident to explore a new support arrangement which was progressing. Another resident explained that they wished to make an observation and clarified it wasn't a complaint in relation to the accessibility to nursing care. This resident explained that staff are trained to dress wounds but they indicated that they would prefer a nurse to dress their wounds more regularly. This was discussed with the management team and it was explained that they limited the staffing entering apartments during the COVID-19 outbreak that they had recently. Management explained that a new nurse was recently employed and due to start soon and will take over the dressing the wounds for this resident. Another resident raised a concern in relation to the staffing levels and explained that they did not always receive the one to one staffing support hours that were allocated to them when they first moved to the centre and stated that the staff are run off their feet.

The inspectors observed that each resident had their own self contained apartment which was very personalised and decorated in line with their specific care needs and personal preferences. Some apartments were equipped with assistive and smart technology to further support and facilitate the resident's independence where appropriate. A number of issues with some of the resident's equipment was also noted such as a shower chair in two resident's apartments, a resident's wheelchair and another resident's bed were noted on the day of the inspection and for the most part, the provider was aware and addressing these. The inspectors also observed that a number of residents began to decorate their apartments for Christmas. Some resident's decorated their apartments themselves and others were provided with assistance from family members or staff.

On the day of the inspection, some residents had gone to work, to their day service or college, others attended various social engagements and personal appointments with allied health professionals, others hosted visitors, another was observed reading the newspaper and some others decided to stay and relax in their home as they were feeling unwell. A number of residents described their typical routine to the inspectors which included going to work, going shopping in the city, going to the pub, going for dinner, participating in quiz's, going to the cinema, and meeting friends and family.

A number of residents also advised that they attend residents meetings regularly and advised that if they can't attend the meeting, they are sent the notes from the meeting afterwards. One resident showed an inspector a project they were involved in that they raised at a residents meeting which involved improving the distribution of post system in the centre. The resident explained that they were encouraged and supported by staff to plan and coordinate the project and showed the inspector the shelving unit which provided each resident with an individual box/shelf to receive their post and parcels.

Aside from times when residents and staff were seen to interact when in residents' apartments, some respectful and positive interactions were observed by the

inspectors in communal areas of the larger building. On multiple occasions, staff members were seen to be respectful of residents' privacy by knocking on residents' apartment doors and waiting on a response before entering. At one point during the inspection, the person in charge was overheard giving a resident an update about some correspondence that had been received which was relevant to that resident. Later on, it was seen that the person in charge bought some raffle tickets from a resident who selling them on behalf of the Irish Wheelchair Association.

In summary, the residents gave positive views of the centre, although some expressed concerns regarding the staffing. As will be discussed below, significant improvements were required to ensure that the service provided was safe at all times and to promote higher levels of compliance with the regulations. This was observed in areas such as; governance and management, staffing, training and staff development, premises, protection against infection and fire safety. The next two sections of this report outline the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and standards. Inspectors found that this centre met the requirements of the regulations in some areas of service provision. However, improvements were required, particularly in areas such as; governance and management, staffing, training and development and contracts for provision of services.

Records of audits reviewed during this inspection included audits carried out in areas such as safeguarding and health and safety. The provider had also conducted regulatory requirements such as the annual review and the provider six monthly unannounced visits, however only two six monthly audits had been carried out since the centre's previous inspection in March 2020.

During the course of this inspection, an inspector saw a record of communication from the provider's Chief Executive Officer from August 2021 highlighting that the provider's senior management had significant concerns around the services being provided to residents in this designated centre. Such concerns related to cultural matters and aspects of the staffing arrangements that were in place. This was discussed with those directly involved in the management of the centre during this inspection who acknowledged the contents of the provider's communication while it was also highlighted that during this time period there had been a lack of oversight by the provider, both locally and nationally for this designated centre. It was noted though that since August 2021, the provider had been taking steps to address such issues. For instance; a programme of staff training in various areas had also been introduced and a review of staff rosters also recommenced in August 2021 that was due for completion in January 2022.

The purpose of this roster review was to ensure that staffing hours were allocated to times that were most beneficial for residents. While this was a positive development, it was noted that this roster review had not been completed having first commenced in 2019. The staffing arrangements were generally in keeping with the centre's statement of purpose but there were times when this was not always the case. For example, from speaking with residents and reviewing complaints there had been times when some staff arrangements had been cancelled at short notice without being replaced, despite efforts to prevent this, and they did not always receive the one to one staffing support hours that were allocated to them. In addition, the centre had recently been impacted by a COVID-19 outbreak which impacted its staffing levels. While staff was maintained at essential levels during this time, in line with the provider's COVID-19 emergency plan, a complaint record from one resident was reviewed where they had highlighted that they were left waiting 15 to 20 minutes for staff assistance for a toilet transfer during the outbreak.

As per the provider's policy, formal supervision for staff members was to be carried out every three months but from records reviewed this was not consistently taking place. It was also noted that some staff members were overdue refresher training in some areas such as fire safety, positive behavioural support and safeguarding. During the inspection a sample of staff files were reviewed and it was found that these files contained the majority of the required information such as evidence of Garda Síochána (police) vetting and written references. However, It was noted that some documents such as evidence of completed qualifications and recent photo identification were missing from some files.

While a number of the required notifications as required by the regulations had been submitted in a timely manner, it was noted that HIQA had not received a recent quarterly notification report relating to restrictive practices used in the centre. In addition, when reviewing complaints records, an inspector read a complaint a resident made in relation to staff. While this complaint was addressed and followed up in line with the provider's complaints process, it was not regarded as a safeguarding concern and therefore was not notified appropriately to the chief inspector. It was also found that some of the issues identified during the centre's last inspection in relation to a resident's contract for the provision of services remained outstanding. While, the provider made efforts following the last inspection to update the resident's service agreement, it was still not in place.

Regulation 14: Persons in charge

The person in charge had the qualifications, skills and experience to fulfill the role. This individual was engaged in the governance, operational management and administration of the centre in a regular and consistent basis. Since recently assuming the role, they put systems in place to monitor the quality of care and support for residents and were found to have a regular presence in the centre. For

the most part, they were identifying areas for improvement in line with the findings of this inspection and were focused on quality improvement and on ensuring residents were happy and safe in their homes.

Judgment: Compliant

Regulation 15: Staffing

There was a staff rota in place and it was reflective of the staff on duty on the day of the inspection. The provider ensured continuity of care through the use of an established staff team and a small number of regular relief staff. Overall the inspector found there were not enough staff on duty at all times and their were a number of staff vacancies in the centre which were impacting on the quality of service provision.

It was highlighted to inspectors that there was a need for a staffing roster review to ensure that staffing was appropriate to meet the needs of residents at all times. From speaking with residents, and staff as well as reviewing documentation, it was found that the number of staff employed were not always appropriate to the meet the residents needs. For example, from speaking with one resident and reviewing complaints there had been times when some staff arrangements had been cancelled at short notice without being replaced despite efforts to prevent this. Another resident also complained that they did not always receive the one to one staffing support hours that were allocated to them when they first moved to the centre and advised that the resident was worried something bad will happen due to staff shortages. In addition, the centre had recently been impacted by a COVID-19 outbreak which impacted its staffing levels. It was communicated that a review of the staff roster had re-commenced to ensure that the appropriate staffing levels were allocated to times that were most beneficial for residents. Records reviewed indicated that this issue was identified and the roster review which had initially began in 2019 had recommenced.

A sample of personnel files were reviewed to ensure the provider had a record of key documentation relating to staff members as required by the regulation. From the sample reviewed it was seen that these files contained the majority of the required information such as evidence of Garda Síochána (police) vetting, written references and full employment histories. It was noted though that some documents such as evidence of completed qualifications and recent photo identification were missing from some files.

Judgment: Not compliant

Regulation 16: Training and staff development

The staff were supported and facilitated to access appropriate training including clinical training that was in line with the residents' needs.The inspectors viewed evidence of mandatory and centre specific training records. There was a system in place to alert staff when refresher training was due. It was communicated also that the provider was introducing a new training academy programme that would further improve the current system in place. It was found that the provider was also self identifying additional training programmes to further meet the resident's needs. For instance; they had a plan in place to provide training in skin care and pressure ulcer prevention and diabetes training. However, while training was in place, there were a small number of staff requiring refresher training in areas such as fire safety, positive behavioural support, safeguarding and in a small number of the centre specific clinical training programmes such as catheter care. The provider had a plan and scheduled dates in place for outstanding training to be completed in January 2022.

Supervision records reviewed and discussions with staff highlighted that one to one formal supervision had taken place. Some staff communicated that informal supervision is provided to staff on an ongoing basis also. However, it was found that formal supervision was not taking place at intervals in line with the providers own policy. The provider's policy states that supervision should occur minimally once per quarter. Upon review of a sample of supervision records, formal supervision had not occurred once per quarter. This was not in line with the stated policy. For example, some staff members' most recent formal supervision took place in February 2021, and July 2020 for one staff member.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure with clear lines of accountability and responsibilities. The registered provider had appointed a full time, suitably qualified and experienced person in charge who was able to discuss with inspectors key issues relating to the governance of the centre. The person in charge was supported by a senior management team in the centre, a regional manager and quality partners within the organisation. It was found that the management team met regular basis.

Records of audits reviewed during this inspection included audits carried out in areas such as safeguarding and health and safety. The provider had also conducted regulatory requirements such as six monthly provider unannounced visits. However, only two had been carried out since HIQA's previous inspection in March 2020, most recently in June 2021. An annual review of the service had also been completed for 2020 and it was noted that a copy of this annual review was available for review in the reception area of the larger building. The 2020 annual review included feedback from residents living in the centre. However, it was noted though that the annual

review did not provide for consultation with residents' families.

During the course of this inspection, an inspector saw a record of communication from the provider's Chief Executive Officer from August 2021 highlighting that senior management had significant concerns around the service being provided to residents in this designated centre. Such concerns related to cultural matters and aspects of the staffing arrangements that were in place. This was discussed with those directly involved in the management of the centre during this inspection who acknowledged the contents of the provider's communication while it was also highlighted that during this time period there had been a lack of oversight by the provider, both locally and nationally, for this designated centre. This was evidenced in the findings of non compliance found on this inspection.

It was noted though that since August 2021 the provider had been taking steps to address such issues and those involved at an executive and senior level of management within the provider were involved in these efforts. A new system of monthly audits had been introduced which commenced in this centre in September 2021 although further such audits had not been carried out at the time of this inspection owing to COVID-19 related issues. A programme of staff training in various areas had also been introduced and a review of staff rosters also recommenced in August 2021 that was due for completion in January 2022. The purpose of this roster review was to ensure that staffing hours were allocated to times that were most beneficial for residents.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

It was found that some of the issues identified during the centre's last inspection in March 2021 in relation to a resident's contracts for the provision of services remained outstanding. During the last inspection, there was a lack of clarity as to whether the resident's tenancy charge was weekly or monthly, if the resident's representative was the appropriate person to sign the contract for the provision of services, and there was a lack of clarity in relation to what charges the resident incurred other than their tenancy charge. The inspectors were provided with information that outlined clearly the charges in relation to this resident's provision of care and the efforts that the provider made following the last inspection to update the resident's service agreement to reflect same. However, this service agreement was still not in place. A number of other contracts for the provision of services and tenancy agreements were reviewed also. It was unclear if an appropriate representative signed some of these contracts, where the resident was not in a position to.

Judgment: Not compliant

Regulation 31: Notification of incidents

Documentation in relation to notifications which the provider must submit to HIQA under the regulations were reviewed during this inspection. Such notifications are important in order to provide information around the running of a designated centre and matters which could negatively impact residents. While a number of the required notifications had been submitted in a timely manner, it was noted that HIQA had not received a recent quarterly notification in relation to restrictive practices used in the centre. In addition, when reviewing complaints records, an inspector read a resident's complaint in relation to staff. While this complaint was addressed and followed up in line with the provider's complaints process, it was not regarded as a safeguarding concern and therefore was not notified within three working days as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

Records of any complaints made were kept. When reviewing these it was noted that these records contained details of the complaints made, actions taken in response to these and whether or not residents were satisfied with the outcome of their complaints.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the centre presented as a comfortable home and provided person centred care to the residents. A number of key areas were reviewed to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, a review of personal healthcare plans, risk documentation, fire safety documentation, and protection against infection. The inspectors found some evidence of residents being well supported in some areas; such as their healthcare and general welfare and development. However, improvements were required in relation to relation to fire

safety, the premises, protection, and infection prevention and control measures.

The designated centre and residents' apartments were provided with fire safety systems which included a fire alarm, emergency lighting, fire extinguishers and fire hoses. Regular internal staff checks were were in place but it was found that improvements were required to ensure the fire alarm and emergency lighting were serviced at quarterly intervals. It was also found that the use and maintenance of fire doors required review. For example, in some apartments fire doors were observed to be held open, and a noticeable gap was evident at the bottom of the door in one apartment. Improvement was also required regarding fire drills carried out in the centre. For instance; a fire drill which reflected a night time situation, when staffing levels would be at their lowest, had not been carried out since February 2020, while the residents living in the apartments outside the larger building had not taken part in a drill since December 2019.

Personal protective equipment (PPE), including hand sanitizers and appropriate hand washing facilities were available and were observed in use in the centre on the day of the inspection. However, improvement was also identified regarding some of the infection prevention and control practices in the centre. For instance; from a sample of records reviewed, staff were not always checking their temperature twice a day in line with COVID-19 national guidance. Cleaning schedules were in place, however, gaps were evident in cleaning records reviewed which indicated that some cleaning was not being carried out as scheduled.

The centre comprised of a purpose-built facility of self-contained apartments. While for the most part the premises was well maintained and was in a good state or repair, there were a number of areas that required attention. The provider had self-identified a number of these areas and there was a plan in place to address them. For instance; they were waiting on parts to repair the front door and the elevator. The provider had also just discovered a leak in one of the respite apartments and the inspectors were informed that this water leak had been identified the previous day and was in the process of being rectified. In addition to this, the inspectors also found that some of the resident's equipment required review and repair for instance; and a resident's wheelchair, a bed for one resident and shower chairs for two residents. While work had begun, it was also found that actions agreed from the last inspection in March 2020 in relation to the apartments with non-automated doors was not complete.

The provider had detailed risk assessments and management plans in place which promoted safety of residents and were subject to regular review. The registered provider took measures to ensure the residents healthcare needs were met. There were systems in place to ensure that residents were safeguarded from abuse in the centre. Where there were safeguarding concerns, for the most part, there was evidence that appropriate safeguarding plans were in place which were monitored, reviewed and dealt with appropriately. However, when reviewing complaints records, an inspector read a resident's complaint in relation to staff. While this complaint was addressed and followed up in line with the provider's complaints process, it was not regarded as a safeguarding concern and therefore was not

investigated as such.

The inspectors found that a number of the residents were very independent and where required residents were supported and facilitated to participate in activities, employment and educational programmes of their choice. Residents were facilitated to welcome visitors into their apartments also. It was observed that personal care practices respected resident's privacy and dignity. The staff were seen to interact with residents in a respectful and dignified manner. Staff were seen to offer residents the opportunity to exercise choice and control in their daily lives. For instance, this was observed that staff would wait for a response from the residents before entering their apartment and offered the choice to speak with the inspectors. The residents also had access to advocacy services and were consulted and encouraged to participate in how the centre was run.

Regulation 11: Visits

Based on discussions with residents, residents were able to receive visitors to their apartments in the designated centre. One of the inspectors also met a resident's visitors in their apartment.

Judgment: Compliant

Regulation 13: General welfare and development

The inspectors found that a number of the residents were very independent and where required residents were supported and facilitated to participate in activities, employment and educational programmes of their choice. The COVID-19 outbreak impacted this somewhat but the residents' spoken with understood the need to restrict movements for that period of time. The inspectors found that the residents had opportunities to develop and maintain personal relationships and links with the wider community. The provider had a community and therapeutic facilitator who would meet with the residents regularly to discuss personal goals and activities they would like to engage in and assists them in planning same. These plans are outlined in the residents' future plan and reviewed by the community and therapeutic facilitator. It was found that the service introduced a new goal tracking system to ensure the residents goals were broken down into manageable steps and were part of their daily activities and plans to ensure they were achieved. Inspectors also found that where residents did not wish to engage in this process, that choice was respected. These residents were invited to participate anytime, if they changed their mind and it was also found that it was discussed again during the residents annual review process.

Judgment: Compliant

Regulation 17: Premises

The centre comprised of a purpose-built facility of self-contained apartments. It was made up of a larger building with individual apartments and staff facilities for up to 10 residents while a further six apartments were located just outside this building. The larger building also contained other rooms and apartments which was were not part of the designated centre and used as office space for other organisations. In general, the premises was designed and laid out to meet the aims and objectives of the service and the needs of the residents. Each resident had their own self contained apartment which was decorated in line with their specific care needs and personal preferences. The residents' apartments were personalized and homely, and were equipped with the aids and appliances required as per their assessed needs. Each apartment also provided residents with ample storage for their personal items.

While for the most part the premises was well maintained and was in a good state or repair, there were a number of areas that required attention. The provider had self-identified a number of these areas and there was a plan in place to address them. For instance; they were waiting on parts to repair the front door and the elevator. The provider and a resident were also waiting six weeks on a part to repair a resident's wheelchair. This part arrived on the day of the inspection and the wheelchair was due to be fixed the day after the inspection. Another resident's apartment was observed as being unclean and untidy and there was a plan in place to address this with the resident. In addition to this, the inspector observed an occupational therapist in another resident's apartment who was visiting to address the shower chair and part of the resident's bed that required repair. A water leak had also been identified that had damaged the flooring in an apartment that is usually used for respite. Inspectors were informed that this water leak had been identified the previous day and was in the process of being rectified.

Another resident, while they said they were generally happy with their apartment, they highlighted an issue with the shower chair available for them in their bathroom. In particular, the resident showed the inspector how this shower chair and the overall layout of the bathroom posed challenges for them when transferring to and from their wheelchair. The resident said that they had raised this issue with staff. It was also noted in another resident's apartment that the door to the bathroom was difficult to open and close properly and required review. In addition to this, an inspector observed an O.T. visiting another resident in relation to the resident's bed and shower chair that required repair.

It was found that actions identified from the last inspection in March 2020 in relation to the apartments with non-automated doors was not complete. It was communicated that funding was secured to upgrade two doors. Upon consultation with residents, it was agreed one of the doors to be upgraded would be the door into a communal area and the other would be for a resident's apartment. It was also noted that additional funding had been applied for to upgrade the other outstanding

doors.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had detailed risk assessments and management plans in place which promoted safety of residents and were subject to regular review. There was an up to date risk register for the centre and individualised risk assessments in place which were also updated regularly to ensure risks were identified and assessed. There was an effective system in place for recording adverse incidents and accidents. This system included an incident analysis that recorded the type of incident, immediate actions taken, if further action was required, whether or not the appropriate authority was informed and if a risk assessment is required.

The centre had up to date risk management policy in place which was also subject to regular review and contained all the information as required by the regulations.

Judgment: Compliant

Regulation 27: Protection against infection

Inspectors found that improvement was required regarding some of the infection prevention and control practices in the centre. When a recent sample of entries in the visitor log it was seen that while visitors were signing in, some were not signing out which reduced the accuracy of the log for contact tracing purposes. It was also found from a sample of records reviewed, that not all staff were checking their temperatures twice a day in line with relevant COVID-19 national guidance. Cleaning schedules were in place for the centre and cleaning was seen to be carried out during this inspection. However, gaps were evident in cleaning records reviewed which indicated that some cleaning was not being carried out as scheduled.

There was information relation to infection prevention and control practices and updated guidelines on visitation that was in line with national guidance available to staff and residents. There was also ample supply of hand gels and personal protective equipment (PPE) and staff on duty were seen to wear face masks. Arrangements were in place for PPE to be disposed of, although at one point during the inspection, an inspector observed a pedal bin for face masks which had one face mask caught in the lid of a bin and was therefore partially hanging outside the bin while another bin for other PPE was full to the top. Later on during the inspection both of these issues had been addressed. Evidence was seen that an infection and prevention control audit had been carried out as well as a relevant self-assessment in this area as issued by HIQA. However, it was noted though that this self-

assessment had not been reviewed since June 2021 despite the centre having had a COVID-19 outbreak since that time.

Judgment: Not compliant

Regulation 28: Fire precautions

The designated centre and residents' apartments were provided with fire safety systems which included a fire alarm, emergency lighting, fire extinguishers and fire hoses. While regular internal staff checks were indicated as being done on the fire safety measures, it was found that the fire alarm and emergency lighting were not undergoing timely maintenance checks by external contractors. These should be serviced at quarterly intervals but from records reviewed, these had only been serviced two times since October 2020. In addition, the use of and maintenance of fire doors in the centre required reviewed. For example, in some apartments fire doors were observed to be held open while in one apartment a noticeable gap was evident at the bottom of the door reducing their effectiveness.

Improvement was also required regarding fire drills carried out in the centre. While multiple fire drills had been carried out in 2021, from records reviewed, these all reflected a day time scenario when staffing levels would be higher with evacuation times ranging from three to nine minutes. Residents living in this centre had particular mobility needs which meant some would require the assistance of two staff to help them evacuate at night while some residents' apartments were on the first floor of the larger building. Despite this a fire drill which reflected a night time situation, when staffing levels would be at their lowest, had not been carried out since February 2020.

In addition, it was noted that no fire drill had been carried out between February 2020 and February 2021 while the residents living in the apartments outside the larger building had not taken part in a drill since December 2019. All residents living in this centre did have personal emergency evacuation plans (PEEPs) which outlined the supports they needed to evacuate if required. While these PEEPs generally contained a good level of information in this regard, some did require improvement. For example, the PEEP of one resident, who lived on the first floor of the larger building, did not outline how the resident was to be evacuated down the stairs if required.

Judgment: Not compliant

Regulation 6: Health care

The registered provider took measures to ensure the residents healthcare needs

were met. Healthcare assessments were in place and reviewed regularly with appropriate healthcare plans developed from these assessments. There was also appropriate personal care plans in place specific to the health care management needs of the residents. There was evidence that residents were facilitated to access medical treatment when required including national screenings. The Inspectors noted there was nursing care provided and the residents had access to and there was input from various health and social care professionals such as occupational therapists and speech and physiotherapists.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to ensure that residents were safeguarded from abuse in the centre. Staff had completed training in relation to safeguarding and protection with the exception of a small number of staff that required refresher training. Staff spoken with, were found to be knowledgeable in relation to their responsibilities should there be a suspicion or allegation of abuse. Staff were also familiar with who the designated officer for the centre was. Residents had intimate care plans in place which detailed the level of support required. Where there were safeguarding concerns, for the most part, there was evidence that appropriate safeguarding plans were in place which were monitored, reviewed and dealt with appropriately. However, when reviewing complaints records, an inspector read a resident's complaint in relation to staff. While this complaint was addressed and followed up in line with the provider’s complaints process, it was not regarded as a safeguarding concern and therefore was not investigated as such.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider ensured residents were consulted and encouraged to participate in how the centre was run. For instance; resident meetings were taking place and the residents were consulted in the annual review for the centre. One resident advised that they suggested a new system where each resident would have their own post box just inside the main door in the lobby area of the main building, where the post would be sorted and each resident can collect their post in their individual post box. The resident was encouraged and supported by staff to plan and the develop the project and showed the inspector the post box on the day of the inspection.

The inspectors found that personal care practices respected resident's privacy and dignity. The staff were seen to interact with residents in a respectful and dignified manner. Staff were seen to offer residents the opportunity to exercise choice and

control in their daily lives. For instance, this was observed that staff would wait for a response from the residents before entering their apartment and offered the choice to speak with the inspectors. The residents also had access to advocacy services.

It was identified at the last inspection that some residents would like to have the staff roster in advance so that they would know who will be supporting them. The inspector reviewed documentation that demonstrated this for a number of residents, however, one resident advised that they were not always given the rota in advance.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Waterford Cheshire OSV-0003457

Inspection ID: MON-0030379

Date of inspection: 01/12/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staff vacancies have been advertised internally and two new external staff are to start employment in January. Residents that request a staff roster will have it sent to them at the beginning of each week in their preferred method of communication and it will now also be cc'd to the service manager for oversight. One resident who has evening social hours that can be difficult to fill at short notice if rostered staff ring in sick will be given a roster even if there are no staff available. One resident has applied for a co-managed individualized budget arrangement. The resident has been approved for same and is being supported by the Local Management Team to progress the assessment as the resident currently does not have an available advocate. Roster review has recommenced to ensure the staff numbers rostered is meeting the needs of all residents and a draft roster will be in place March 2022. The HR files have been reviewed and updated. The admin team will conduct annual reviews of the HR files to ensure all documentation is up to date.	
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training that could not be completed due to covid restrictions has been booked for January and February.

Supervision schedules are being put in place from January and will be reviewed monthly at senior team meetings, and by the Regional Manager at Regional Team meetings to ensure compliance with policy.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In 2020 one planned unannounced inspection could not take place due to covid restrictions on travel and visitation. Alternative arrangements for oversight were put in place via zoom meetings. The bi-annual unannounced inspections of services recommenced in 2021 and will continue in the services.

Responsibility for internal audits will be shared within the Local Management Team led by the service manager and will be completed at the end of each month.

The management plan that was put in place in August was to clarify expectations of staff and address issues within the service by providing training to staff on areas such as policies and procedures. Training has been scheduled to resume end January.

Families will be corresponded with and invited for consultation for the service 2022 annual review as per residents wishes.

Roster review has recommenced and a draft roster will be in place March 2022.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
One resident requires support to sign a contract. Work with an advocate that commenced in 2021 to support the resident will recommence and an agreement will be put in place for the resident, signed by the advocate by June 2022.

All other contracts will be reviewed to ensure that they are signed by the appropriate person by 31/3/ 2022.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
One quarterly notification was missed, the team have discussed this error and put plans in place to ensure there won't be a re-occurrence. CNM will upload quarterly notifications, all other notifications will be uploaded by the management team this will be overseen by Service Manager.

All incidents where a resident uses the word "abuse" when making a complaint will be returned to HIQA as an NF06.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Parts were delivered and the front automated doors are now in full working order.

Parts were delivered and the elevator is now in full working order.

The part for the resident's power wheelchair was delivered and fitted and is now in full working order.

The apartment that appeared unclean and tidy is cleaned regularly by staff when the resident will permit access. Assessments have taken place to identify areas the resident needs more support with and a plan is being put in place in consultation with the resident to address areas identified.

The resident who had an O.T. visit at the time of the inspection to repair a bed had a new bed delivered after it was found that it could not be fixed. The same resident also had an issue with a shower chair and a new one was provided.

Respite apartment leak has been fixed and quotes have been received to replace flooring. This work will be carried out end January/early February.

The O.T visited another resident on 6th January 2022 who had raised issues with a

shower chair and a different type of chair has been fitted as per the resident's request.

Funding was received to automate two doors in the service. Consultation with residents at monthly resident's feedback meetings determined that one door that was to be prioritized was a communal door and this has been fitted. A resident's apartment door will be automated in January with the remaining funding and council grants have been applied for other doors. Confirmation of a grant for one more apartment door was received in January.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Visitors will be reminded to sign out and a reminder notice has been put in place.

All staff have been reminded by memo to record both temperature checks.
A review of documentation will take place as part of weekly senior staff member's role and staff that are not compliant will be met through supervision.

The CNM will meet with the cleaning staff in January and review the cleaning records and identify reasons for gaps in records. CNM will check records weekly for oversight.

HIQA Self assessments will completed as per guidance by CNM and will be reivewed by clinical partner.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A full fire risk assessment with GSP Fire consultancy will be carried out by end March 2022. Recommendations will be reviewed with National Health and Safety Manager as a priority and a plan put in place to action areas required to ensure compliance with fire precautions. The timeframe for completion of actions will be determined once report received and areas identified.

A night time simulation fire drill was carried out 23rd December 2021.

A plan for the year of scheduled fire drills to include internal and external apartments and night time simulations is being complied for the year by the health and safety

representative and reviewed monthly at the senior team meetings.

Maintenance company schedules quarterly visits, some of these were not possible to facilitate due to a Covid outbreak in the service and the maintenance company being affected by Covid also. Internal recording system will be put in place to monitor.

The PEEP for resident living upstairs was reviewed with them in December and updated.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A review of the Safeguarding Policy, reporting requirements and notifications will be carried out with the management team by The National Safeguarding Lead in February 2022. The management team will then discuss with all staff at staff meetings.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Residents that request a staff roster will have it sent to them at the beginning of each week in their preferred method of communication and it will now also be cc'd to the service manager for oversight.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall 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.	Not Compliant	Orange	30/03/2022
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	28/02/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	28/02/2022

	as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/02/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/06/2022
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	28/02/2022
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best	Substantially Compliant	Yellow	30/06/2022

	practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	28/02/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/01/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated	Substantially Compliant	Yellow	31/01/2022

	centre at least once every six months or more frequently as determined by the chief inspector and shall 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.			
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	30/06/2022
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	31/03/2022
Regulation 27	The registered provider shall ensure that residents who may	Not Compliant	Orange	31/01/2022

	be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/06/2022
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/06/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them	Not Compliant	Orange	31/01/2022

	to safe locations.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	28/02/2022
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/01/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure	Not Compliant	Orange	31/01/2022

	including physical, chemical or environmental restraint was used.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	31/01/2022
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	31/01/2022