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:	14 March 2023
Centre ID:	OSV-0003457
Fieldwork ID:	MON-0039076

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:	13

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
Tuesday 14 March 2023	10:00hrs to 15:50hrs	Miranda Tully	Lead
Tuesday 14 March 2023	10:00hrs to 15:50hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This inspection was completed to review progress made by the registered provider following the last inspection of the centre in January 2023. As part of the decision making process for the renewal of registration of this centre, a further inspection was required due to poor compliance with regulations in this centre.

During the previous inspection a number of significant areas of concern relating to fire safety were identified and urgent actions were issued by inspectors for completion by the registered provider. The provider submitted written assurances to the Chief Inspector of Social Services stating that they had completed these actions. A Cautionary meeting was also held with the provider, whereby further written assurances were required and provided by the registered provider.

These submitted assurances formed the basis for this inspection.

The inspectors found that despite the registered provider's submitted written assurances, appropriate corrective actions had not in fact been implemented. For example, a damaged fire door that was reported as being repaired was found in the same condition as per the inspection in January.

As this inspection was focused on a review of the submitted action plans the inspectors did not meet with the number of residents as they had in January. Residents present in the centre were given the option to meet inspectors should they wish to. One resident came to the room inspectors were working in and spent some time talking with inspectors. They stated that they were happy in the centre and liked the staff that supported them. The residents told inspectors that they did not feel that the change in the centres staffing roster had impacted on them and their care and support. The inspectors observed other residents being supported by staff to attend appointments and to leave the centre to attend activities in the community.

On the day of inspection there were a number of positive cases of COVID-19 in the centre and inspectors followed all infection prevention and control guidance throughout the day and limited their access to parts of the centre. Inspectors also met and spent time with the person in charge, the senior support workers and members of the staff and administrative team over the course of the day.

While it was evident that the provider had taken some steps to improve their service in a number of areas, the inspectors found that there remained a significant level of non-compliance in the centre.

The inspectors completed a walk-around of areas of the premises and it was evident that some improvements had been made since the last inspection with regards to works to the premises and infection prevention and control measures. However overall inspection findings did not demonstrate that management systems were in

place to ensure the service provided to residents was safe and effectively monitored and that assurances provided to the Chief Inspector were being implemented at centre level. The next two sections of the report discuss these findings in more detail.

Capacity and capability

Overall, this inspection found that the registered provider had not demonstrated good levels of capacity and capability to provide safe and quality care for the residents at all times.

While inspectors acknowledge that the provider had made progress against a number of Regulations identified as requiring review at the last inspection there were a number of serious concerns that remained outstanding. Of concern to inspectors, was that the providers own assurance and auditing mechanism was not effective. These were reporting that actions were completed and had not identified that they had not been. This included an urgent action issued on the day of the previous inspection to address fire integrity concerns as part of the centre containment system. The provider continued to demonstrate poor oversight in relation to ensuring effective fire containment throughout the centre and limited actions had been completed to rectify these previously identified fire safety issues.

Since the last inspection a new roster had been implemented in the centre, the purpose of the revised allocation of hours was to ensure staffing was appropriate to meet the individual assessed needs of the residents. Meetings were occurring between staff and the local management team during the implementation of the new roster. Inspectors reviewed this roster and the cover that staff provided to individuals and the flexibility this allowed. The person in charge discussed how one resident had reported their dissatisfaction with the rota. A further review of the roster is scheduled to take place in May 2023 to ensure appropriate resources continue to be allocated according to residents' needs.

Regulation 15: Staffing

The provider had made substantial progress towards meeting identified actions in this area. A revised roster had been implemented by the provider in February 2023 in order to meet the current assessed needs of residents. This is scheduled for further review in May 2023 by the provider in order to further assess the effectiveness of the revised staffing allocation.

The person in charge discussed the ongoing communication with residents and the pathways available to them to raise queries and concerns. The person in charge stated that to date only one resident had reported their dissatisfaction with the rota.

The person in charge described how they were working collaboratively with the resident and their key representatives and all stakeholders in order to establish a solution to best meet the resident's individual needs.

Improvements were seen by inspectors on planned and actual rosters reviewed for example, first and second names were listed, along with their role and whether the staff was a relief or agency was visible.

Judgment: Compliant

Regulation 16: Training and staff development

The inspectors reviewed mandatory and centre specific training which had been completed. Inspectors found that some improvements had been made, including a tracking system to establish gaps and training requirements following the introduction of the revised roster in February 2023. However, a number of staff continued to require refresher training in areas such as medication management where eight staff were out of date in their training, one since September 2022. Across infection prevention and control specific trainings such as hand hygiene or Breaking the Chain of Infection in total there were 105 outstanding refresher training events required.

This meant, on the day of the inspection, not all of the staff team had up-do-date knowledge and skills to meet the assessed needs of residents.

Judgment: Not compliant

Regulation 23: Governance and management

This inspection found that the provider continued to be significantly non-compliant in areas identified by inspectors in the January 2023 inspection. There were a number of significant findings on the previous inspection regarding the fire safety practices of this centre which resulted in the provider being required to implement urgent actions on the day of inspection in January 2023. Findings on this inspection were inconsistent with written assurances given to the Chief Inspector by this provider.

Inspectors found that management systems in place did not ensure the service provided to residents was safe and effectively monitored. As mentioned previously, the inspectors found that the registered provider had submitted assurances that actions were completed that had not been carried out, there was no evidence that the management team had physically reviewed the actions and relied on 'word of mouth' assurances. As an example identified repairs stated as completed were not

carried out. The non-completed actions had not been identified in the provider's audits.

While inspectors acknowledge that the provider had made progress against a number of regulations that had been identified as requiring review there were a number of concerns related directly to resident safety that remain outstanding. Of concern to inspectors was that the providers own assurance and auditing mechanism was not effective and was reporting that actions were completed and had not identified that.

Inspector experienced issues and delays gaining access to documentation and relevant information on this inspection. Furthermore inspectors were told that members of the management team were unclear where items were stored or possibly did not have access to other requested items. This did not provide assurance of effective oversight.

Judgment: Not compliant

Quality and safety

On this inspection, inspectors found that while the provider had taken steps to identify and address areas of non-compliance, there continued to be unaddressed issues with fire safety and risk management in the centre. Eight weeks had passed since the previous inspection and while a lot had been achieved in that time-frame, there remained considerable work to be done with some areas already outside of the provider's own identified time frames.

While it was evident that the provider was attempting to improve the quality and safety of the service, there continued to be non-compliance in meeting the assessed support and care needs of residents. The inspectors found that significant improvement was required to ensure the designated centre provided a safe and quality service which was in line with the needs of residents. For example, concerns were noted in areas including fire safety, risk management procedures and protection against infection.

On the walk around of the centre, a fire door on entry to the kitchen area was observed to be compromised and ineffective. The provider had committed to repairing the door following the previous inspection however this had not been completed. The fire risk assessment completed in January noted concerns in relation fire safety however, the measures identified by the provider did not provide a timely response for the risk posed. No subsequent review of the risk assessment for the month of February was available for review on the day of the inspection and the person in charge was unsure if it had been completed.

A number of minor repair works had been completed such as painting and removal of unused furniture. A number of items remained outstanding at the time of inspection such as kitchen and bathroom upgrades. A date for completion had not been identified on the action plan reviewed.

Regulation 17: Premises

The inspectors completed a walk-around of areas of the premises which were un-occupied at the time of inspection, this included two respite apartments, an unoccupied residential apartment and main storage, staff and communal areas within the centre. It was evident that a number of improvements had been made since the last inspection with regards to works to the premises. For example, there was evidence of cleaning, painting and removal of broken furniture. Inspectors found one apartment contained a fridge freezer that had mould internally and was damaged, while this was scheduled for replacement it was still present in a respite apartment.

Additional works such as upgrade of kitchens and bathroom areas remained outstanding however an action plan had been developed with identified works scheduled for completion by the end of April as notified to the Chief Inspector. Large repair works such as roof repairs had been agreed and the inspectors saw costings and confirmed start dates for this work. The provider and person in charge had a premises action plan with descriptions of identified and required actions, a priority rating for completion and an assigned identified owner for the action. A number of these actions were seen to have no specific dates and some were waiting on contractors and on quotes. For a number of the highest priority actions it was noted that the dates 'mid March' were not obtainable for completion as quotes had not yet been received, this included a resident's shower where tiles were falling off the wall and the wall was noted to be 'swollen'.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place and there was a risk register maintained within the centre. However the systems in place were not effective in appropriately managing risks within the centre.

The provider had commissioned a specialist to complete a fire risk assessment in February 2022. Within this report a number of high risk actions had been identified which according to the specialist, required action within three months. For example, a fire door was warped and required repair or replacement, electrical cooking facilities required assessment, some apartment layouts were not as agreed originally

with fire officers and a door to a kitchen was not closing. In addition the report recommended, if the premises were not occupied they should not be until risks had been reduced and if occupied urgent action should be taken.

The risks outlined in the specialist report were included in a locally developed risk assessment developed by senior management a year later in January 2023 with no reduction in the severity of risk noted. In addition, the immediate control measures identified by the provider did not adequately address the concerns in an appropriate time frame. For example immediate controls included, a lead time of six to eight weeks for fire doors reported as ordered, appointment of a contractor in March and a phased plan of works to be then implemented. In addition not all risks had been included in the risk assessment developed locally such as the door to the main kitchen area not closing on the ground floor. No review of the risk assessment was available for the month of February and the person in charge was unsure if a subsequent review of the risk assessment had occurred.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had policies and procedures in place to protect residents and staff from the risk of infection. The infection prevention and control policy had been reviewed and revised on 13 January 2023. Improvements had been made in cleaning practices since the last infection. This included cleaning of the centre and revision of cleaning schedules to ensure all areas of the centre were cleaned on a regular basis. A schedule of works had also been developed to up-grade a number of en-suite bathrooms. The centre sluice room for example had been cleaned and open shelving removed and the cleaning store rooms had new flooring and had been cleaned.

The person in charge had described systems for ensuring residents' equipment was appropriately cleaned and maintained. The inspectors saw the newly established checklists in place to guide staff to clean equipment and to note when they were cleaned, including hoists and wheelchairs. These systems while newly devised had yet to be fully implemented and embedded into practice. However, on the inspection a urine bottle was observed in a box in an apartment identified for respite stays. Areas of the premises which as stated remained outstanding for repair or replacement also prevented effective cleaning and disinfecting although inspectors acknowledge that these are scheduled for repair.

Judgment: Substantially compliant

Regulation 28: Fire precautions

This inspections findings of non-compliance against this regulation reflect the most significant safety concerns for residents.

Inspectors acknowledge that the provider had committed to completing fire safety works as identified on the external specialist report dated February 2022 however, actions which had been identified as a major risk by the external specialist had not been completed at the time of inspection.

As noted previously, written assurances regarding fire made following the January 2023 inspection were found not to be completed.

Improvement was required in the arrangements in place for the safe evacuation of all persons in the event of a fire, particularly at times of minimum staffing. From a review of fire drills completed, the inspectors found that the fire drills did not demonstrate that all residents could be safely evacuated at times with the lowest number of staffing.

Inspectors were not assured all residents could be accessed in the event of a fire from a protected hallway to allow for safe egress. Also, the layout of some apartments was of concern to the inspectors as there was no means of containing the spread of fire and smoke into a residents' bedroom from a kitchen area.

Judgment: Not 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 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Waterford Cheshire OSV-0003457

Inspection ID: MON-0039076

Date of inspection: 14/03/2023

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A training schedule is in place to ensure that Medication Management and IPC training, and relevant refresher training are completed by 12th May 2023, in order to ensure that all of the staff team will have up-do-date knowledge and skills to meet the assessed needs of residents. The Regional Manager will review the training records for all staff on her fortnightly visits to the service. Training is a specific agenda item for these site visits to ensure oversight of completion of training. Training from May will be monitored and scheduled each quarter to ensure all staff that are due training will have this completed within correct timeframe.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Waterford HIQA inspection of 14th March 2023 was included as a specific item on the agenda for the Cheshire Ireland Quality Safety and Risk Management Sub-Committee (QSRM) meeting of 28th March 2023. An Extraordinary Meeting of the QSRM Sub-Committee was convened on 28th March 2023 with the only agenda item being the Waterford HIQA inspection of 14th March 2023. The Waterford HIQA inspection of 14th March 2023 was included as a specific item on the agenda for the Cheshire Ireland Board of Trustees Meeting of 29th March 2023.	

At each meeting the details of the inspection and the planned actions and oversight were discussed.

Weekly meetings are scheduled from 18th April in order that the CEO will receive updates from relevant functions within the organisation as to progress on actions relating to the Service.

Following these meetings, the CEO will send a written update to the Chairman of the Board of Trustees and the Board HIQA Provider Representatives as to progress of actions.
The Chairman of the Board of Trustees will be updated verbally at least fortnightly on progress of actions by the CEO.

The Regional Manager will visit the service fortnightly to ensure oversight of the service and notes of these meetings will be shared with the Head of Operations and CEO.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A premises action plan with descriptions of identified and required actions, a priority rating for completion and an assigned identified owner for the action is in place in the Service.

This will be updated by PIC and Maintenance Manager as works progress.

This will also be reviewed and monitored by Regional manager on fortnightly visits to monitor progress and will be reported and shared with CEO and Head of Operations Cheshire Ireland.

Contractor has been approved for roof repair works. Work to commence these repairs are to commence on 19th April 2023

Works has commenced on upgrade of bathrooms and tiling on 17th April 2023 and to be completed by 12th May 2023.

Fridge freezer identified during inspection has been disposed of and replaced.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Review of Service by National Risk Manager and action plan developed with timelines.

The Fire Risk Assessment for the service is up to date and available to all staff in the service.

This will be reviewed by the National Risk Manager and Regional Manager monthly and will be shared with the Service Manager to print and share with all staff and other relevant parties.

The Regional Manager will view this Risk Assessment on her fortnightly visits to ensure

oversight.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: Areas identified by inspectors during inspection have been included in local premises action plan. Cleaning procedures and schedules in the service have been reviewed and cleaning staff and the local management team updated on the changes made to these. While extensive cleaning has taken place and new cleaning procedures are in place in the Service, Contract cleaners will attend the Service to complete a deep clean. To be completed by 12th May 2023. IPC refresher training for all staff that includes hand hygiene in progress and will be completed by 12th May 2023.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire Schedule of works has been reviewed and funding has been approved by Cheshire Board. This will be broken down into 3 phases. Contractor has been appointed for these works following Etender process. The 3 phases of works are to be completed by 30th November 2023. In relation to the fire door works required in the service: – Confirmed order of the fire doors for Waterford on the 23rd of March 2023. – Work commenced on 5th April for the remedial works to the existing doors. – The doors are due to the service week of the 24th of April 2023. – Expected completion date 12th May 2023. Fire Drills – fire drills are underway to ensure that residents can be safely evacuated when minimum staffing on duty. Will be completed by 12th May 2023 Fire Training for Management – specific Fire Training has been undertaken (31st March 2023) with the management team in the service with a particular focus on fire drills, evacuations and documentation.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	12/05/2023
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	12/05/2023
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	Substantially Compliant	Yellow	12/05/2023

	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.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	12/05/2023
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	12/05/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	12/05/2023
Regulation 27	The registered provider shall	Substantially Compliant	Yellow	12/05/2023

	ensure that residents who may 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	12/05/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	12/05/2023
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	12/05/2023