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:	Cara Cheshire Home
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	26 April 2022
Centre ID:	OSV-0003441
Fieldwork ID:	MON-0032187

About the designated centre

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

Cara Cheshire Home provides support to adults with primarily physical disabilities and or neurological impairments 24 hours per day seven days per week. Staff support people with a variety of disabilities including the following: cerebral palsy, multiple sclerosis, hydrocephalus and acquired brain injuries. Some residents have secondary disabilities which could include an intellectual disability, mental health difficulties or medical complications such as diabetes. The centre is set on extensive grounds set in park lands, which is located near Dublin city centre and other amenities. Currently there are 11 people living in Cara Cheshire House, each with their own individual bedroom. The accommodation at Cara Cheshire House is suitable for a maximum of 14 residents. The service has a large dining room, a laundry, kitchen, an activities room, office spaces, a large sitting room, a sun room, landscaped grounds, a patio area, a quiet room and a family room. The service has a range of staff supporting the individuals living here which include a service manager, nursing staff, service coordinator, activities coordinator, senior care staff, care support workers, domestic and kitchen staff, administrators, a maintenance/driver person, a community employment supervisor, and a team of community employment staff who assist in maintenance, driving and activities. There is also a multi-disciplinary team based in the service on a part-time basis who support the individuals and the staff team to assist them.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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 26 April 2022	09:45hrs to 17:15hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection, scheduled to monitor ongoing regulatory compliance in the designated centre. Additionally, the inspection set out to monitor progress the provider was making in meeting the requirements of a restrictive condition which was attached to the centre's certificate of registration. This restrictive condition required the provider to make improvements to the physical environment of the designated centre in order to provide for a more homely environment and to enhance the quality of life of residents. The provider was required to make these improvements by 30 June 2022.

The inspector had the opportunity to meet most of the residents on the day of inspection. Some residents chose to speak to the inspector in more detail about their experiences of living in the designated centre. The inspector used observations, interactions with residents and staff, as well as a review of documentation to form judgments on the quality and safety of care in the centre. The inspector wore personal protective equipment (PPE) and maintained physical distancing as much as possible during interactions with residents and staff.

Overall, the inspector saw that the provider had made progress in enhancing the physical environment of the designated centre. Extensive premises works had been completed in particular areas, including resident bedrooms. Residents had access to large bedrooms which were decorated in line with their personal preferences and choices. The corridors in bedroom wings had also been redecorated and were homely and welcoming. The provider had commenced works in other areas of the designated centre. While these were incomplete at the time of inspection, the provider was confident that they would be completed by 30 June 2022 in line with the requirements of their restrictive condition.

The inspector observed residents freely accessing various parts of their home. Some residents were engaged in a music class while others relaxed in the sitting room or conservatory. Some residents chose to access the community and were supported to do so by staff. The inspector was informed that the provider had recently purchased additional buses to enhance residents' access to the community. One resident told the inspector that the staff were very helpful and supportive when they wanted to get the bus into town.

Most of the residents who spoke to the inspector told her that they liked living in the designated centre. Many had lived there for a considerable length of time. They stated that they were happy with the works that the provider had completed to date and were looking forward to the works being fully completed.

Resident and staff interactions were noted to be friendly and relaxed. Staff and residents appeared to know each other well and shared jokes with each other. The inspector saw staff assisting residents with activities of daily living in a gentle and respectful way. Staff spoken with were aware of residents' assessed needs and of

their preferences when it came to their personal care. Residents informed the inspector that their preferences in relation to personal care and support were respected.

The next two sections of the report will present the findings of the inspection in relation to the governance and management arrangements in place and how these impacted on the quality and safety of care in the designated centre.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspector found that, while the provider had mechanisms in place to support oversight of the quality and safety of care, improvements were required to the local governance arrangements to ensure that actions were progressed in a timely manner and that policies were implemented as prescribed by the provider.

There was a clearly defined management structure in the designated centre. There were several staff in senior roles who were supernumerary to the roster. The centre was run by a person in charge who was supported in their role by a service coordinator and a clinical nurse manager 1 (CNM1). These positions were supernumery to the roster. The centre staffing allocation also included a full-time housekeeping and catering team which were led by a head chef. However, in spite of these oversight structures, the inspector found that there were delays in responsible people addressing areas of need and that there were gaps in the implementation of policies such as staff supervision. These delays placed residents at risk as not all staff were fully informed regarding residents' care plans and risk assessments.

The inspector was informed that the responsibility for supervision of staff was divided amongst the person in charge, CNM1, service coordinator and head chef. However there was no clear supervision schedule which detailed when supervision meetings were to be be held. The provider's policy set out that supervision was to be completed quarterly however, the inspector found that only eight out of the 43 staff on the roster had completed a supervision meeting in the first quarter of 2022.

The inspector reviewed the training matrix and identified that while much training, including safeguarding and first aid, was up-to-date, several staff were overdue training in areas such as feeding, eating, drinking and swallowing and epilepsy. These trainings were available online and the inspector was informed that staff had been advised to complete them. Without regular supervision, there was no consistent record of how individual staff were performance managed and supported to exercise their professional responsibility.

Staff informed the inspector that they attended staff meetings every six weeks and

that they felt comfortable bringing issues and concerns to the attention of senior management. A review of staff meeting records showed that they covered topics relating to the quality and safety of care including infection prevention and control, staffing issues and service updates.

A review of the roster demonstrated that the service employed a high number of staff. The service was operating with one 36 hour per week vacancy. This vacancy was filled by a panel of in-house relief staff which supported continuity of care for residents. The roster showed that the number and skill mix of staff on duty, each day, was sufficient to meet the needs and number of residents. An activities co-ordinator enhanced the staffing complement and supported residents during the week and at weekends to engage in meaningful and personalised activities in the centre and in the community.

The provider had in place a series of audits to support oversight of the centre. These audits were completed in consultation with residents and staff and accurately reflected the issues and risks presenting in the service. An improvement plan was derived from these audits which highlighted risks and identified actions to address these risks. However, the inspector saw that some of these actions had not been completed in a timely manner. An unannounced audit completed in October 2021 had identified several actions, many of which remained incomplete. For example, this audit had identified that enhancements were required to ensure that all staff were aware of residents' choking care plans. Some residents had detailed protocols in place to mitigate against the risk of choking. However, the audit identified that this action was "ongoing". The inspector saw, on the day of inspection, that not all staff were aware of these care plans and, on one occasion, a residents' feeding, eating, drinking and swallowing care plan was not implemented as prescribed.

Additionally, the audit in October 2021 identified that some risk assessments required amending as they were inadequately detailed. The inspector also identified this as a risk on the current inspection. While risk assessments were in place in the centre, they were inconsistent in their risk ratings across similar risks and did not detail sufficient control measures. This will be discussed further in the quality and safety section of the report.

The provider had a complaints policy in place which had been recently reviewed and detailed clear procedures for the management of complaints. There was also an easy to read complaints procedure displayed in a prominent place in the centre. Residents informed the inspector that they were aware of the procedure to make a complaint. The inspector saw that there had been a high number of complaints made in the last 12 months although the provider noted that this was a decrease on the previous 12 months. Many of these complaints were attributed to a lack of available space for residents while building works were ongoing and the provider was hopeful that the completion of building works would have a positive impact for the residents. The inspector saw, that where complaints had been made, that these had been responded to in line with the provider's policy.

Regulation 15: Staffing

The designated centre employed staff with an appropriate skill mix to meet the needs of residents. The staffing complement was enhanced by the allocation of a full-time catering and housekeeping team as well as an activities co-ordinator.

The centre was operating with one 36 hour whole time equivalent vacancy at the time of inspection. The provider filled any gaps in the roster from a panel of in-house relief staff. This supported continuity of care for residents. A roster review was completed which demonstrated that staffing levels were appropriate to meet the assessed needs of residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A training matrix was maintained for the designated centre which identified that the majority of staff were up-to-date in key mandatory trainings including safeguarding, managing behaviour that is challenging and first aid. Gaps were identified in the following trainings:

- Fire safety: four staff required this
- Medication management: three staff required this
- Feeding, eating, drinking and swallowing (IDDSI): four staff required this
- Epilepsy: three staff required this

Some of these trainings were available online. The inspector was informed that staff had been advised to complete these however it was not clear how staff were supervised to ensure that this was done.

The provider's supervision policy set out that staff supervisions were to be held quarterly. The inspector saw that the majority of staff had not received a supervision in the first quarter of the year. There was no supervision schedule available to demonstrate when supervisions would take place.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place in the designated centre and the provider had effected a series of audits to monitor the quality and safety of care. However, the inspector saw that action plans from these audits were not

implemented in a timely manner and several actions which presented a risk to residents remained outstanding five months after the audit. For example, actions requiring enhancements to residents' care plans and risk assessments had not been implemented.

Additionally, the inspector found that arrangements to support and develop all members of the workforce required enhancement. The provider had effected a supervision policy and there was evidence that supervision meetings had taken place for some staff within the first quarter of the year. However, the majority of staff had not received a supervision meeting in line with the provider's policy.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had effected a complaints policy which had been recently reviewed. There was an easy-to-read complaints procedure poster available to residents in the centre. Residents spoken with were aware of how to make a complaint. The inspector saw that there had been a significant number of complaints made. The provider had attributed many of these to the inconvenience of the building works on residents' lives and daily activities. Complaints had been responded to in line with the provider's policy.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspector saw that the provider was in the process of making changes to the physical layout of the building in order to enhance the quality of service to residents. Generally, residents were found to be in receipt of an individualised service which was respectful and person-centred. However, improvements were required to the risk assessments and to residents' care plans to ensure that the service was being provided in a safe manner.

The provider had made significant changes to the premises of the designated centre. Residents' bedrooms and the bedroom wings were found to have been particularly enhanced. Resident bedrooms had been made bigger and were furnished with the necessary equipment in line with their assessed needs. Resident bedrooms were also decorated in line with their individual preferences. The provider

had repurposed vacant bedrooms into store rooms for resident equipment. This contributed to a more homely feel in the centre as unused equipment was stored out of sight. The inspector saw that one resident's wardrobe was damaged and required repair and that the protective cover on one armchair in another resident's bedroom was peeling. These presented an infection prevention and control risk as they could not be cleaned properly.

The provider was in the process of completing other premises works at the time of inspection. Staff and residents spoke positively regarding the premises works although they did acknowledge that such significant work had interrupted their lives and had been inconvenient, at times. A new, accessible residents' kitchen was being fitted. This would support residents in preparing their own meals. A quiet room was also in the process of being refurbished. Further works such as replacing flooring and painting in the main corridor remained outstanding. The provider was confident that this work would be completed in the time frame as required by the restrictive condition attached to their certificate of registration. Some other minor works were required in the centre. For example, the inspector saw that the walls in a sluice room were damaged and required repair.

Residents' meals were prepared in a kitchen by a catering team. The inspector saw that meals that were on offer were nutritious and presented in an appealing way. There was a menu available to residents which offered choices in line with residents' assessed eating and drinking needs. Residents did not have access to facilities to prepare and cook their own meals however the provider was in the process of addressing this at the time of inspection. The provider had commenced the installation of an accessible residents' kitchen in the centre.

The inspector saw that there were sufficient staff to support residents at mealtimes however not all staff had completed the required training. A risk was also identified whereby a resident was not supported with their meal as per their assessed need and associated care plan. The provider attributed this to not all staff being aware of the residents' feeding, eating, drinking and swallowing care plan.

Residents' files were reviewed and it was found that residents had an up-to-date assessment of need completed which was used to inform care plans. Residents' care plans were informed by multidisciplinary professionals as required. However, the inspector found that not all care plans were sufficiently detailed to ensure that staff were aware of the specific support needs of residents. For example, one feeding, eating, drinking and swallowing care plan stated that a resident required close supervision during mealtimes in order to reduce the risk of choking. Staff spoken with were unable to define what was meant by close supervision. Additionally, this resident was observed eating a meal unsupervised on the day of inspection. It was therefore not evident that care plans were fully implemented by staff in the centre. The provider's own audit in October 2021 had identified that a risk in the centre was that choking care plans were insufficiently detailed and that not all staff were aware of these. The inspector found that this risk continued to be present in the centre on the day of inspection.

Residents' files also contained positive behaviour support plans for those residents

who required them. These were written in person centred language and in a respectful manner. However, it was not clear that these support plans had been updated at least annually, as there was no available documentation to support this. Restrictive practices in place in the centre had been logged and notified to the Chief Inspector as required by the regulations. There was evidence that restrictive practices were regularly reviewed and that consideration was given to using the least restrictive practice for the shortest duration possible.

All staff had completed training in safeguarding vulnerable adults. Staff spoken with were knowledgeable regarding their safeguarding roles and responsibilities. There was accessible information available to residents in the centre on safeguarding and how to contact confidential recipients. Where safeguarding concerns had been identified, these had been reported to the safeguarding team and to the Chief Inspector and safeguarding plans had been implemented. Additionally, where there had been an allegation of abuse, the provider had completed an investigation of this matter. Intimate care plans were available on residents' files. These were written in person centred language and clearly detailed residents' preferences when it came to support with their intimate care. Residents informed the inspector that their wishes were respected in relation to their care needs.

A risk register was maintained for the designated centre. Individual risk assessments were also available. However the inspector found that not all individual risk assessments correlated with the risk register. For example, the risk of residents smoking in the centre was rated as a moderate (orange) risk on the risk register, however an individual resident's smoking risk assessment assessed this as a negligible (yellow) risk. Additionally, risk assessments did not provide sufficient information regarding control measures to reduce a risk particularly in relation to fire risks as a result of smoking. Individual risk assessments did not include the use of call bells, or pendants for residents to summon help if they required it in the event of a fire in their room. These were control measure which the inspector was informed of verbally on the day of inspection. The provider's unannounced audit in October 2021 had also identified that some risk assessments were insufficiently detailed.

Generally, the provider had effected mechanisms to contain, detect and extinguish fires. The majority of staff were up-to-date in fire safety training. Staff spoken with were knowledgeable regarding fire evacuation procedures and fire safety. Regular fire checks were completed and fire equipment was serviced and maintained. Monthly fire drills were held which provided for a range of scenarios. The provider demonstrated that all residents could be evacuated with the minimum of two staff in ten minutes. However, the inspector found that improvements were required to the fire evacuation scenarios used in order to give consideration to the presenting risks in the centre. For example, the high risk areas such as utilities and resident smoking bedrooms were located in the central area of the centre. Most fire drills evacuated past these areas. The provider had not attempted a fire drill away from these areas. On walking the fire exit route at the end of the corridors, the inspector was not assured that all residents could be evacuated through this exit in the manner as set out by their personal evacuation plans.

The provider had policies and procedures in place to ensure effective infection prevention and control. The designated centre was observed to be clean and tidy. Temperature checks and symptom checkers were completed regularly for residents and staff. The inspector saw that all staff, including maintenance staff and builders were wearing appropriate personal protective equipment (PPE). The centre had access to a housekeeping team seven days a week. Housekeepers were knowledgeable regarding infection prevention and control measures such as using colour coded cloths and different mop heads for each zone. There was an adequate supply of hand washing facilities and hand sanitising stations throughout the centre. Regular audits were completed of staffs' hand hygiene practices as well as their knowledge of respiratory hygiene, the management of blood and spillages and knowledge of standard precautions. The centre had an updated COVID-19 contingency plan which was in line with current public health guidance.

Regulation 17: Premises

The provider was in the process of completing premises works at the time of inspection. The inspector saw that residents had access to enhanced personal space. Resident bedrooms were observed to be personalised and decorated in line with individual preferences. There was sufficient storage for equipment through the repurposing of vacant bedrooms. The provider had adapted the building to provide for separate staff changing areas and offices which were located away form the residents' living space. This further contributed to enhancing the homeliness of the centre. Other works were ongoing in line with the provider's service improvement plan. These works including fitting a residents' kitchen, a quiet room and replacing flooring and painting main corridors. The inspector saw some minor cosmetic issues which required addressing. These included repairs to a resident's wardrobe and armchair and repairs to a sluice room wall.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents had access to meals which were wholesome and nutritious. Meals looked and smelled appealing. There were choices of meals and snacks available to residents which were in line with their assessed needs. Food was prepared in a kitchen by a catering team. Residents did not have access to their own facilities to store, prepare and cook food however the provider was in the process of addressing this. There were sufficient staff available to support residents at mealtimes however not all staff had received training or were fully aware of residents care plans in relation to their eating and drinking.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The systems in place for the assessment, management and ongoing review of risk required enhancement in the designated centre. The provider had identified this in their own audit in October 2021 however this action had not been addressed. The inspector found that the risk register did not correlate with individual risk assessments in some cases and that not all risk assessments provided sufficient detail in the control measures to be used to mitigate against the risk.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider had adopted procedures consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority. The inspector saw that there was a good standard of environmental cleanliness maintained in the centre and that staff were knowledgeable regarding infection prevention and control. There was an up-to-date COVID-19 contingency plan which was in line with current public health guidance.

Judgment: Compliant

Regulation 28: Fire precautions

Generally the provider had effected mechanisms to contain, detect and extinguish fires. Staff had received training in fire safety and were knowledgeable regarding fire evacuation procedures. Regular fire drills were completed with a variety of scenarios. however, consideration was not given to the presenting risks in these scenarios. For example, fire drills scenarios did not include the risk of fire in residents' bedroom or the utility room in the central area of the designated centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of need was available on the resident files which were

reviewed on the day of inspection. This assessment of need was informed by multidisciplinary professionals as required and was used to inform care plans. Care plans were in place for each assessed need. However, the inspector saw that not all care plans were sufficiently detailed to ensure that staff were aware of the specific support needs of residents. Additionally, some staff were unaware of these care plans. On the day of inspection, the inspector saw that one resident's care plan was not followed which placed this resident at risk of choking. The inspector was informed that not all staff were aware of this care plan.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Behaviour support plans were on file for those residents who required them. The inspector was informed that these were reviewed annually however improvements were required to the documentation of reviews to ensure that this was recorded.

Restrictive practices were logged and notified in line with the requirements of the regulations.

Judgment: Substantially compliant

Regulation 8: Protection

Information was available to residents on safeguarding. Staff had received training in safeguarding vulnerable adults and were knowledgeable regarding their safeguarding roles and responsibilities. The provider had investigated any allegations of abuse and had notified the national safeguarding office and the chief inspector as required by the regulations.

Intimate care plans were available on residents' files. Staff spoken with were aware of residents' preferences and choices in relation to their personal care. Residents informed the inspector that their choices and preferences were respected.

Judgment: 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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cara Cheshire Home OSV-0003441

Inspection ID: MON-0032187

Date of inspection: 26/04/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Recruitment process is ongoing to fill any vacant contract hours and is expected to be finalized by 30/06/22.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A supervision schedule is now in place and all staff will be provided with their timeframes for same by end of 31/05/22. • All staff will have a support and supervision meeting by 30/06/2022 and then quarterly as per supervision schedule and policy. • Fire Safety Training that requires to be face to face will take place on 16/06/22 for the 4 staff that require same. • Staff who require to update their training online in the identified areas have been spoken to and will have completed same by 15/06/22.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • All actions from Provider 6month audits will be copied to the Service Action Tracker as SMART actions to ensure they are completed in a timely manner. The Service Acton Tracker will be reviewed regularly by the Person in Charge and the Regional Services Support Team. • A supervision schedule is now in place and all staff will be provided with their timeframes for same by end of 31/05/22. • All staff will have a support and supervision meeting by 30/06/2022 and then quarterly as per supervision schedule and policy.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A premises maintenance audit took place on 13/05/22 and items requiring repair/replacement were identified with timeframes of completion by 30/06/22 for priority areas and 31/07/22 for other actions. • A premises maintenance audit will be undertaken each quarter by the PIC and the Maintenance Lead.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: • Risk Assessments in relation to Choking and Aspiration for identified individuals have been provided to all kitchen staff with requirement that they are read and understood by 31/05/22. SLT plans are displayed in the kitchen. • Risk assessment and Care Plan for noted individual as requiring further detail has been amended to be more descriptive. • All care plans are being reviewed/revised by CNM1 and Clinical Partner to ensure they contain clear direction for staff as to the manner in which support should be provided. Completion date 30/6/22. • 2 new staff have completed IDDSI training at end of April and start of May. • 2 staff who require update in their IDDSI training will have same completed by 15/06/22.	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The CNM1 will conduct a review of all risk assessments by 30/06/22 to enhance/update same and will ensure dates of same are in line with the risk register.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • 2 alternative evacuation routes are now included in the schedule of fire drills.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Risk Assessments in relation to Choking and Aspiration for identified individuals have been provided to all kitchen staff with requirement that they are read and understood by 31/05/22. SLT plans are displayed in the kitchen. • Risk assessment and Care Plan for noted individual as requiring further detail has been amended to be more descriptive. • All care plans are being reviewed/revised by CNM1 and Clinical Partner to ensure they contain clear direction for staff as to the manner in which support should be provided. Completion date 30/06/22.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive	

behavioural support:
• Positive Approach Plans are in place to support individuals where there is a need and these are reviewed on an ongoing basis by the Regional Quality Partner.
• The Quality Team have amended the template for these plans to capture and reflect clearly at least quarterly reviews for updates/amendments required in line with what is going on for the person. Reviews using the new template will be completed by 30/06/2022.

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.	Substantially Compliant	Yellow	30/06/2022
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.	Substantially Compliant	Yellow	30/06/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/06/2022

Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/07/2022
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook their own meals if they so wish.	Substantially Compliant	Yellow	30/06/2022
Regulation 18(3)	The person in charge shall ensure that where residents require assistance with eating or drinking, that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.	Substantially Compliant	Yellow	31/05/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated 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	Substantially Compliant	Yellow	30/06/2022

	in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/06/2022
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.	Substantially Compliant	Yellow	30/06/2022
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	Substantially Compliant	Yellow	31/05/2022

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/05/2022
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/06/2022