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:	Wolseley Lodge
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Carlow
Type of inspection:	Announced
Date of inspection:	23 September 2021
Centre ID:	OSV-0005342
Fieldwork ID:	MON-0026518

About the designated centre

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

Wolseley Lodge is a detached two storey dwelling located on the outskirts of a town for four people, male or female, over the age of 18 years. This dwelling consists of eight bedrooms. The bedrooms which are occupied by residents are ensuite. The remaining bedrooms are used for office space for staff and one is used as a storage room. There is a open plan kitchen/dining/lounge area which has double doors linking the patio area and garden. The centre provides a service to people with physical disabilities including wheelchair users, and is staffed both day and night. The service is operated as a nurse led model with the additional support of care staff and ancillary supports such as maintenance, gardening and transport as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 - 2015 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
Thursday 23 September 2021	9:45 am to 4:45 pm	Ciara McShane	Lead
Thursday 23 September 2021	9:45 am to 4:45 pm	Jennifer Deasy	Support

What residents told us and what inspectors observed

Inspectors had the opportunity to meet with all three residents on the day of inspection. Some residents wished to speak to inspectors in more detail while others preferred to go about their daily activities. Several family members took time to speak to inspectors either by phone or face to face. At all times, inspectors wore face masks and maintained social distancing, in line with current public health guidance during our interactions with residents, family members and staff. Inspectors used conversations with residents, family members and key staff, observations and a review of documentation to inform judgments on the quality of care in the designated centre.

Overall inspectors found that residents were happy with the quality of care that they were receiving in their home. Residents and family members spoke well of the staff in the designated centre. They described staff as friendly, nice and approachable. Family members felt that they could bring concerns or issues to the staff and that these would be listened to and addressed. Family members commended staff on supporting them to maintain contact with their loved ones who were living in the designated centre during COVID-19 restrictions. Family members expressed to inspectors that they felt their loved ones received an individualised service where their wishes and choices were respected. One family member commented on how staff go "above and beyond" what is expected of them. They gave the example of staff going to a local coffee cart to bring a takeaway coffee back for a resident when the resident was not feeling well enough to go out themselves.

Inspectors observed that the designated centre was decorated in a homely manner. Residents each had access to their own large en-suite bedroom which was decorated according to their personal tastes. The designated centre was observed to be clean and tidy. Inspectors observed staff cleaning high traffic areas throughout the day. Inspectors also saw that staff were wearing face masks and engaging in regular good hand hygiene practices. Residents were observed using the communal dining area for meals, watching television (TV) in the sitting area and meeting family members in the garden outdoors. While residents had access to a communal living area, there was no private space available to residents to receive visitors other than in their bedrooms or the garden. Feedback was provided to the inspectors by family members that this is an area that they would like to see improved.

Staff and resident interactions were observed to be friendly and warm. Staff were observed sitting with residents during mealtimes and engaging in casual conversations. Staff were also observed to communicate with residents in a manner which respected residents' dignity and autonomy. For example, staff were observed asking residents if it was okay to assist them before doing so. Staff regularly checked in with residents while they were engaged in quieter activities such as watching TV to see if they needed any support.

The next two sections of this report present the inspection findings in relation to the

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 to contribute to the decision-making process for the renewal of the centre's registration. Inspectors found that this centre met the requirements of the regulations in many areas of service provision. However improvements were required, particularly in the area of governance and management.

There was a suitably qualified and experienced person in charge who had oversight of another designated centre in addition to the current unit. This person in charge was employed in a full-time capacity. There was a clearly defined management structure in place which identified lines of authority and accountability. The designated centre had an assistant manager in place who reported directly to the person in charge. This supported the person in charge in their governance, operational management and administration of the designated centre.

It appeared to inspectors that there were sufficient staff in the designated centre on the day of inspection in order to provide care and support to the number of residents. A planned and actual roster was maintained. However, the specific role of the staff were not detailed on the roster. This made it difficult for inspectors to determine if staffing was appropriate to the assessed needs of residents. Inspectors were informed that the designated centre provided an outreach service to individuals in the community. While the roster allocated a staff member to provide this service, the number of hours which were being provided was not accounted for on the roster. The impact of this on the designated centre's staffing complement and on the support needs of residents had not been assessed.

An up-to-date statement of purpose was in place in the designated centre. The statement of purpose was found to contain much of the information as required by Schedule 1 of the regulations. However, inspectors found that the statement of purpose did not accurately reflect the total staffing complement for the designated centre. The statement of purpose also did not detail the outreach service and the impact of this, if any, on service provision.

A training matrix was maintained which accurately reflected the training completed by the designated centre's staff. All staff had completed mandatory training in areas including fire safety, safeguarding and medication management. Some staff required refresher training in areas such as first aid, catheter care and epilepsy. Most staff required updated training in managing behaviour that is challenging. The person in charge had secured dates in the coming months to support all staff to access most of the required refresher training. However, there was no date identified for staff for required refresher training in managing epilepsy.

Staff in the designated centre had access to regular supervision, the frequency of which was found to be in line with the provider's policy. A review of supervision records found that the content of supervision was appropriate to the needs of staff. It was clear that where actions were identified in supervision that these were followed through. The person in charge also had access to regular supervision which was in line with the provider's policy.

There was evidence that regular meetings were scheduled by the registered provider in order to support them in having oversight of the designated centres in the area. For example, records of monthly regional management meetings and weekly local management meetings were maintained. The provider had completed an annual review of the quality and safety of care of the designated centres in this area. This review reported that consultation was carried out with residents across the eastern region and their views were reported collectively. The annual review was therefore not an accurate reflection of the quality and safety of care being provided specifically in Wolseley Lodge. The suggestions, feedback and lived experiences of residents' in Wolseley Lodge were not explicitly set out in the review.

The provider had completed two unannounced audits within the last 12 months. The provider had also completed a quality site visit to all units in the area. The findings of these site visits to all local centres were reported collectively and were not specific to Wolseley Lodge. Where actions were identified, these were not specific or measurable. For example, a quality site visit report carried out in July 2021 stated that "all reviews are scheduled for people who live in Wolseley Lodge". There were no details on the time frame for these reviews to be completed within or who had been allocated the responsibility of completing them.

A review of the designated centre's adverse events register (AER) found that not all incidents had been notified to the Chief Inspector as required by the regulations. Two incidents, one involving a fire alarm activation and one involving an allegation of abuse, had not been notified. There was no evidence that a preliminary screening of the allegation of abuse had taken place. The fire alarm activation occurred as a result of smoke from the stove and had resulted in a compartment evacuation of residents. There was no evidence that the cause of this incident had been investigated or that learning from this incident had taken place. A review of notifications submitted to the Chief Inspector, found that an additional incident had not been reported accurately, with this incident reportedly involving more residents than reside in the designated centre.

Regulation 14: Persons in charge

There was a suitably qualified and experienced person in charge who was employed in a full-time capacity. This person in charge had oversight of an additional designated centre. There were effective management systems in place to support

the person in charge in having oversight of the two designated centres.

Judgment: Compliant

Regulation 15: Staffing

An actual and planned roster was maintained. However the role of all staff members were not clearly detailed on the roster. Additional hours being provided as an outreach service from the designated centre were not detailed on the roster. The impact of the outreach hours on the allocated staffing to the designated centre had not been assessed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A training matrix was maintained which demonstrated that most staff had completed mandatory training in key areas. There were some gaps in refresher training identified. The provider had implemented a training plan in order to complete required refresher training before the end of the year.

The outstanding training for staff included:

- managing behaviour that is challenging
- first aid
- epilepsy
- hygiene/cough etiquette
- catheter care

Judgment: Substantially compliant

Regulation 23: Governance and management

While an annual review and six monthly unannounced visits had been completed by the registered provider, these were not specific to this designated centre. The views, feedback and suggestions of the residents had therefore not been accurately captured and reflected in these reviews. Where actions had been identified, these were not always set out in a manner which was specific, measurable or time-bound.

This was also true for local audits. Trending and analysing of incidents and accidents were not always completed specifically for this centre. Therefore it was unclear what

learning was gained and how it was applied specifically to this centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was in place. This statement of purpose contained much of the required information as set out in Schedule 1 of the regulations. Improvements were needed in the detailing of the staffing arrangements in the designated centre. Further information was also required on the provision of an outreach service from the designated centre's staffing complement.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the notifications submitted to the Chief Inspector within the last 12 months and of the designated centre's adverse events register was completed. These reviews demonstrated that not all notifications were submitted to the chief inspector as required.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that the day-to-day practice within this centre ensured that residents were safe and were receiving a quality service. Residents were seen to be treated with dignity and respect and the care provided was appropriate to the residents' needs and was person centred. A consistent staff team worked at the centre and those spoken with were knowledgeable of residents' needs and the local policies and procedures. Areas for improvement such as fire safety, medication management and risk management were identified whereby the provider had failed to fully meet the requirements of the regulations.

The inspectors found the premises to be well maintained, homely and for the most part laid out to meet the needs and number of residents. Each resident had a large spacious bedroom which facilitated the storage of their equipment such as hoists and mobility aids. Each bedroom was complete with an ensuite and was personalised to reflect the things and people that were most important to them.

There was a well maintained garden to the rear of the centre, with seating available and there were also raised vegetable beds which one resident in particular liked to spend time on. There was also a large open plan kitchen, living and dining room area. One aspect noted for improvement was the lack of indoor space for residents to meet visitors in private outside of their bedroom.

From a review of residents' assessment of needs and personal care plans it was evident that residents were receiving care that was person centred, tailored to meet their needs and focused on supporting residents to achieve best possible health. Where needs were assessed as requiring support, a support plan was developed and was further reinforced by a risk assessment. It was evident that personal care plans were reviewed at a minimum annually or sooner if there was a change in need. It was also apparent the provider was utilising approved assessment tools such as Malnutrition Universal Screening Tool (MUST), pressure ulcer risk assessment tools and falls risk assessment tools to inform the plan of care.

Residents had access to a range of allied health professionals and multi-disciplinary supports as required. This was evidenced through attendance at specialised clinics, chiropodist, psychiatrist, dietitians, speech and language therapist and their local General Practitioner (GP) as recorded in their plans. Some of the residents had dementia and while their immediate needs were being met the provider was endeavoring to put a plan in place with regards to future proofing and access to dementia related supports in line with their changing needs.

Similarly the inspectors found the arrangements in place to safeguard residents were appropriate and residents were protected from abuse. Staff spoken with were knowledgeable on both local and national procedures and were all up-to-date with the relevant safeguarding training. Whilst there were no live safeguarding concerns at the time of inspection the inspectors reviewed one incident which had not been screened in line with policy. This was brought to the attention of the person in charge at the time of inspection.

Inspectors found there were appropriate practices in place for the administration and safe storage of medications, including controlled medications. One medication, used for thickening fluids, was found to not be stored safely. An immediate action was issued to the provider who took steps to remove the medication and store it safely on the day of inspection. Staff spoken with were knowledgeable as to the residents' needs in relation to medication. Staff could describe how they ensured medications were provided in a dignified manner. Staff were also clear on the process to be followed should a medication error occur. A log of medication errors was maintained in the centre's adverse events register. An up-to-date medication management policy was on file. There were individual assessments of capacity for residents to manage their medications available on a selection of resident files reviewed.

Arrangements were in place for the management of risk at the centre. There was a site specific health and safety folder which outlined roles and responsibilities in addition to documents such as the centre's emergency plan. A risk register was maintained as too were individual and centre risks. These were reviewed and

updated regularly. One area for improvement in relation to risk management was identified and that was to ensure that risks outlined in the centre's risk register and risk folder were only specific to the designated centre. Recording risks of other units may cause confusion for staff. A log of accidents and incidents were maintained for the centre. An analysis of the incidents and accidents was also available however similar to the risk register the analysis included all of the units and it was therefore difficult to ascertain what the site specific learnings were, if any.

The provider had endeavoured to protect residents, staff and visitors from the risk of fire, however at the time of this inspection improvements were required in particular relating to the containment of fire and safe evacuation. The centre was equipped with fire-fighting equipment such as fire extinguishers and a fire alarm system which was working at the time of inspection. There was also documentation to evidence that equipment was regularly serviced. Fire doors were also fitted throughout the centre however some of the fire doors were potentially ineffective as there were gaps apparent in a number of the doors. The seal around the attic trap door appeared to be ineffective also. Both of these findings required a review.

Each resident had an up-to-date personal evacuation plan which for the most part detailed the residents' specific needs however all evacuation scenarios for the residents were not outlined within. For example, two residents had two potential evacuation routes from their bedrooms, both of which required different modes of evacuation i.e. wheelchair use or use of the resident's bed, depending on the time of day. In two of the personal evacuation plans only one of the exit routes was addressed.

The inspectors reviewed the record of the provider's fire drills and noted that while they had completed some phased evacuation and simulated night time drills they had not completed a full evacuation of residents with the lowest number of staff which for this centre which was one while the waking night staff waited on a roving staff in the nearby area. It was therefore unclear if the staff could safely evacuate all residents in all scenarios in a timely manner. The provider confirmed they would action this in a swift manner. Finally, although there was a night-time evacuation displayed in the centre, a daytime evacuation plan was not on display. This required a review to ensure staff were kept informed of the relevant evacuation routes and plan.

With regards to infection prevention and control (IPC) the provider had adequate arrangements in place. To ensure the ongoing protection of residents, staff and visitors during the COVID-19 pandemic temperatures were checked on arrival to the centre and throughout the day. There was adequate supply of hand hygiene gel and personal protective equipment (PPE) in the centre and additional practices such as designated entry and exit points were also utilised. The provider had an outbreak contingency plan in place, in addition to isolation plans for residents and risk assessments which were reviewed and updated to reflect changes in control measures such as the vaccination status of residents and staff. Other areas of good practice in relation to IPC were identified including a high standard of hygiene in bathrooms and a well maintained centre. There was also evidence that water was

tested for bacteria such as Legionella and Escherichia coli (E.coli).

Inspectors saw evidence that the designated centre was operated in manner that respected the rights of each individual resident. Residents were supported to avail of an individualised service in relation to meal and activity planning. Staff showed inspectors the residents' meal diaries which detailed how residents each choose different meals depending on their individual preferences. Inspectors observed residents eating their individually prepared meals at different times throughout the day as was their preference. There was a log maintained of residents' choices to refuse medical treatment and these choices were respected. Where residents had refused a treatment or intervention, this was explored with them and further information or an alternative service was offered. Intimate care plans were maintained for residents who required them. These care plans documented respectful choices regarding residents' preferences for the type of clothes they wear and which staff they prefer to support them with intimate care.

Regulation 11: Visits

While the registered provider facilitated visitors in accordance with the resident's wishes, there was no suitable private area, which was not the resident's room, in order for these visitors to be received. Family members expressed to inspectors that this was an area that they would like to see improved.

Judgment: Not compliant

Regulation 17: Premises

The premises of the designated centre was designed and laid out to meet the aims and objectives of the service and the number and needs of the residents. The premises was well maintained and was in a good state or repair both externally and internally. Residents had access to their own individual bedroom and en suite which was equipped with the aids and appliances required as per their assessed needs.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had risk management procedures in place which included the centre's emergency plan and a risk register. Inspectors found that the risk register detailed risks in other local designated centres in addition to Wolseley Lodge. Improvements were required to how adverse incidents and events were

recorded in order to investigate and learn from these as they specifically relate to the designated centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider had in place procedures to ensure that residents were protected from acquiring a healthcare associated infection. These procedures included using PPE, temperature checks and regular hand hygiene practices. Up-to-date COVID-19 contingency plans were in place. There was evidence that the water in the designated centre was tested for Legionella and E. coli.

Judgment: Compliant

Regulation 28: Fire precautions

Improvements were required in the area of fire containment and evacuation procedures. Several fire doors were noted to be potentially ineffective as there were gaps around the door which could allow smoke to penetrate the room. Individual evacuation plans were in place for each resident however these did not detail all potential evacuation routes and the different modes required to support the resident to evacuate through each route. Fire drills had not been completed with the lowest number of staff available. It was therefore unclear if staff could evacuate all residents within a safe time frame. Finally, a day time evacuation plan was not displayed in the designated centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

One medication was noted to be stored in an unsafe manner. This medication was a thickening powder used to thicken fluids. This medication presented a risk to residents if accidentally ingested. The provider took immediate action on the day of inspection to address this risk and moved the medication to the locked medication press.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of need had been carried out for each resident and was available on their individual files. Support plans were in place for each assessed need. It was evident from a review of these plans that residents were receiving care which was person-centred and tailored to meet their assessed needs. The assessments of need were up-to-date, having been reviewed within the last 12 months.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a range of allied health professionals and multi-disciplinary supports as required. This was evidenced through attendance at specialised clinics, relevant multi-disciplinary professionals and their local General Practitioner (GP) as recorded in their plans. The registered provider was also engaging in planning for future-proofing the centre to meet residents' needs as they may change in line with their diagnoses.

Judgment: Compliant

Regulation 8: Protection

The registered provider had arrangements in place to safeguard residents and to protect them from all forms of abuse. Staff spoken with were knowledgeable on both local and national procedures and were all up-to-date with the relevant safeguarding training. Whilst there were no live safeguarding concerns at the time of inspection the inspectors reviewed one incident which had not been screened in line with policy. This was brought to the attention of the person in charge at the time of inspection.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors saw evidence that the designated centre provided a service which was person-centred and respected individual residents' dignity, choice and autonomy. There was evidence that residents were actively consulted with regarding the day to

day running of the centre and that their individual choices and preferences were respected. Residents availed of individualised meal and activity planning. Residents' choices to decline medical interventions were also respected. Where residents declined interventions this was recorded and attempts were made to source an alternative treatment which may be deemed suitable by the resident. Intimate care plans were in place for residents who required them. These were written in a respectful manner which took into account individual wishes and preferences in relation to their intimate care.

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 - 2015 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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Wolseley Lodge OSV-0005342

Inspection ID: MON-0026518

Date of inspection: 23/09/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The centre roster will identify all the roles and job titles by October 31st, 2021. • Identified staff from the centre who support one person in the community will be rostered separately to the main roster by October 31st, 2021. • The additional hours required to support the one person in the community and the care needs analysis of the current residents in the centre will be reviewed by November 30th, 2021 to ensure that all of their needs are addressed within their current service agreement / care package arrangements and that they are not negatively impacted by the outreach support service.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • First Aid Training will be completed by October 31st, 2021 • Catheter Training will be completed by November 30th 2021 • Epilepsy Training will be completed by November 30th 2021 • Hand Hygiene and Cough etiquette by November 30th 2021 • Managing behavior that challenges will be completed by December 31st, 2021	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • Whilst 6 monthly unannounced audits specific to this centre are undertaken the person in charge will ensure that all local audits undertaken will ensure/continue to ensure that learning and feedback specific to this centre is identified and reported. • The person in charge will continue trending and analysis of adverse reports and will ensure learning and feedback specific to this centre is documented separately. • The next Annual Service Review for 2021 will be specific to this centre and will be completed by 31st January 2022.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • The SOP will be reviewed and updated to include the staffing arrangements and the details of the outreach service by November 30th 2021	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • The omitted notifications identified have now been retrospectively notified. Completed • Adverse event books will be reviewed weekly to ensure that all notifications are submitted in a timely manner. Completed and ongoing. • The Cheshire National Safeguarding Lead will meet with the Designated Officers, Coordinators and Nurses to give clarity and support relating to the reporting and notifying of NF06's by December 31st, 2021.	

Regulation 11: Visits	Not Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
• The assistant manager will engage and consult with service users and their family members by December 31st, 2021 to establish with them how private visits can best be accommodated within the house.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge and the Clinical Partner will review the risk register in the centre and remove any risks that are not center specific by November 30th 2021.

• Adverse events will continue be reviewed weekly in the centre and also at local management meetings. Ongoing

• AERs for the centre will continue to be recorded in separate adverse event books. Ongoing

• Learnings and any actions from AER's will continue to be recorded on the individual AER tracker for the centre which also highlights trends in AER's recorded for the year to date.

• Actions from the learning and review specific to the centre will be documented in local management meetings and communicated to all relevant staff and residents.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Cheshire Ireland Health and Safety Lead will conduct a review and inspection of the fire doors by November 30th, 2021 and any actions deemed necessary will be addressed.

• Individual resident evacuation plans will be reviewed and updated where necessary by October 31st, 2021 to include all the potential routes.

• In addition to the ongoing night time fire drill simulation of one service user evacuation, a full evacuation of all 3 service users by one staff will now commence, with the first one to be completed by November 30th, 2021.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: SLT recommended drink thickener is now, and will continue to be, stored in a safe and secure manner.	

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 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident; a suitable private area, which is not the resident's room, is available to a resident in which to receive a visitor if required.	Not Compliant	Orange	31/12/2021
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	30/11/2021

Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/10/2021
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	31/12/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/11/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	31/01/2022

Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	30/11/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/11/2021
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 to safe locations.	Substantially Compliant	Yellow	30/11/2021
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	Not Compliant	Orange	30/11/2021

	followed in the case of fire.			
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	30/11/2021
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	13/10/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/11/2021
Regulation 31(1)(c)	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 fire,	Not Compliant	Orange	13/10/2021

	any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.			
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	31/10/2021