<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Cheshire Foundation in Ireland (t/a Cheshire Ireland)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0011353</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Wicklow</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:mark.blake-knox@cheshire.ie">mark.blake-knox@cheshire.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Cheshire Foundation in Ireland (t/a Cheshire Ireland)</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Mark Blake-Knox</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Shauna Bradley</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Julie Pryce</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>21</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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</tbody>
</table>
About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 10 April 2014 11:00  
To: 10 April 2014 19:30

The table below sets out the outcomes that were inspected against on this inspection.

|-------------------------------|----------------------------------------|-----------------------------------------------|----------------------------------|-------------------------------|-------------------------------|----------------------------------|---------------------|-------------------------------------|

Summary of findings from this inspection

This was the first inspection of this designated centre to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013. The inspector met with management, residents and staff members during the inspection, observed practice and reviewed documentation such as personal plans, medical records, accident and incident records, meeting minutes, policies and procedures, staff training records and staff files.

The designated centre comprised 15 chalets which were around courtyard areas, 2 cottage areas and a large main house which was now mostly administration. The centre was comfortable and homely, and for the most part met the residents’ individual needs. Most residents were accommodated in individual bungalows with a sitting room, kitchen, bedroom and bathroom. These homes were decorated in accordance with residents’ wishes, and their personal belongings were evident. However, there were some improvements required in the accommodation of two residents who still lived in the main building in which the other bedrooms were now used as offices.

While the inspector found evidence of a good quality service in the main, improvements were required in the areas of personal planning, risk management,
medication management and staffing. These are further discussed in the body of the report and included in the action plan.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Judgement:
Non Compliant - Major

Outstanding requirement(s) from previous inspection:

Findings:
There was evidence of systems in place to provide a meaningful day for residents, social outings were organised including cinema, shopping and bingo, and staff reported that volunteers were invaluable in the provision of these services. Residents were involved in the running of the centre, and regular residents meetings were held and minuted. However, there were no personal plans in place for the majority of residents, and the inspector was concerned as to how the residents’ social needs were assessed and met in the absence of any supporting documentation.

Personal plans had been commenced for five of the residents, and staff informed the inspector that the intention was to complete plans for every resident. However, even where these plans had been commenced, they did not include an assessment of residents’ social care needs.

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services
Judgement:
Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

Findings:
Residents were accommodated for the main part in self contained bungalows around courtyards. The communal areas, including the gardens, were homely and attractively decorated. The individual homes contained residents’ personal belongings and were decorated and equipped to meet each individuals’ needs.

However, two residents were still accommodated in the large main building which, apart from a communal living room and dining room on the ground floor was mainly an administrative building containing various offices. The room of one resident was on the first floor, and was the only bedroom amongst staff offices.

This was the only area of this outcome to be examined during this inspection.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Findings:
The inspector found that while the provider had put risk management measures in place, some improvement was required.

While there was a risk management policy in place it did not include many of the requirements as set out in the Regulations, for example, the management of self harm, accidental injury, aggression and violence.

A risk register had been devised in which risk assessments were rated, controls identified and date of action taken identified. However, individual risk assessments for residents were not present in their personal records.

Fire safety procedures were well managed, however, some improvements were required in relation to conducting fire drills. Staff were able to tell the inspector about what they would do if the fire alarm went off. There were personal evacuation plans in place for all
residents, the local fire brigade visited the centre three times a year to ensure familiarity with the layout of the centre and annual fire training for staff was up to date. However, while a plan was in place to conduct fire drills they were not up to date on the day of the inspection.

**Outcome 08: Safeguarding and Safety**

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe Services

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
A policy to guide staff in the use of restrictive practices had been ratified and piloted in another services, but had not yet been implemented in the designated centre. There was no evidence of daily recording of restrictive practices, and no evidence of risk assessments. The inspector was concerned that not all alternatives to restrictive practice had been tried or considered and ruled out.

The inspector reviewed a restraints database, and found it to be a list of restraints and enablers, and found no evidence of audits of restrictive practices.

The inspector found that the provider had systems in place to manage residents’ personal finances. Residents had their own personal bank accounts and their rents and costs were paid by direct debit from these accounts. Personal spending was managed with the assistance of staff for the most part. Money was held in each resident’s personal cash box, receipts and signatures were evident for each transaction and any cash withdrawals had two staff signatures verifying them. However there was no written policy to guide staff in the management of residents’ finances, as further discussed under outcome 18.

An intimate care policy was in place and was sufficiently detailed to guide staff practice.

Staff members could discuss the protection of vulnerable adults, they could identify different types of abuse, outline the procedure to follow in the case of suspected abuse, and could name the designated person in the protection of vulnerable adults.
Call bells of a design to meet the needs of each resident were present in the accommodations, and were observed by the inspector to be answered promptly.

All interactions with residents were observed by the inspector to be respectful and caring.

Outcomes 11. Healthcare Needs
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

**Judgement:**
Non Compliant - Major

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

**Findings:**
The inspector found some arrangements in place to support the healthcare needs of residents, but found that substantial improvements were required in the areas of assessment of needs and care planning.

Healthcare assessments and plans were in place for only five of the 21 residents. Where they were in place goals had been set and plans relating to healthcare needs documented. The implementation of these plans was being documented. However, the majority of residents had no care plan relating to their healthcare needs. The inspector was concerned as to how healthcare needs were being met and monitored given the lack of supporting documentation.

For example, the inspector found a fluid intake chart in place for a resident, but that staff did not know the reason for this chart. There was no documentation in the personal plan of the resident relating to an assessment of need or care plan.

Other healthcare needs were also found not to have been assessed or planned for, and the inspector was concerned that health care could not be delivered consistently without this documentation. For example, there was no evidence of a care plan for a resident with an acute chest infection. The inspector discussed these concerns with the operations manager on the day of the inspection who agreed to address the planning of care for acute or changing needs as a matter of priority, and to submit a timeframe to the inspector following the inspection, which was completed as requested.

Residents had access to general practitioner (GP) services, most residents had the same GP, but reported that they had made this choice because of the level of service provided.
There was evidence of a good standard of care in relation to seating and positioning of residents. There was access to a seating clinic for those residents who required this input, and there was evidence of good pressure area care in that no residents had wounds or pressure area breakdown.

There was evidence of systems in place to ensure a balanced and nutritious diet for residents, however, improvements were required in the quality of the food served at some meals and in the policies available to guide staff in meeting the nutritional needs of residents.

There was evidence of input from the speech and language therapist for those residents who required it, and the recommendations were clearly displayed and available to staff. Information relating to modified diets was also clearly available.

Menus were planned a week in advance by the qualified chef. Choice was offered at each meal and if a resident did not want either of the choices offered an alternative was made available.

Snacks were available regularly throughout the day, and food and snacks were available during the night.

However, the majority of residents informed the inspector that they were unhappy with the quality of the meals at teatime. There was evidence from the records of residents meetings that a similar complaint had been made about the midday meals, and also evidence that this complaint had been addressed and improvements made to this meal. The inspector observed the food prepared at teatime and found that the modified diets in particular looked unappealing.

There was no evidence of a policy to guide staff in the area of nutrition, or in the management of dysphagia, despite the vulnerability of residents in this area. This is further discussed under outcome 18. No staff training had taken place in the management of dysphagia, as further discussed under outcome 17.

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**Outcome 12. Medication Management**

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

**Theme:**
Health and Development

**Judgement:**
Compliant

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

**Findings:**
The inspector reviewed a policy on the management of medication and found that there were some improvements required. This is further discussed under outcome 18.

Staff had received training in the safe management of medications, the records of this training were available and staff were able to discuss describe and demonstrate safe administration of medication.

The timing of prescriptions and the guidance for the administration of ‘as required’ (PRN) medications required improvement as further discussed under outcome 18.

**Outcome 14: Governance and Management**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Leadership, Governance and Management

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The person in charge was on annual leave on the day of the inspection. The deputy to the person in charge, the operations co-ordinator, was appropriately skilled, qualified and experienced, and there was evidence of appropriate leadership.

There was evidence of a clear management structure and processes, for example there were regular meetings, both of staff meetings in the designated centre and organisational meetings.

Audits had been conducted in order to review the quality and safety of care and support of residents, and the person in charge had put in processes to address the major risks identified, for example the lack of personal plans for residents. However, the audit had not resulted in a timeframed action plan against which to monitor its implementation.

**Outcome 17: Workforce**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and*
recruited, selected and vetted in accordance with best recruitment practice.

**Theme:**
Responsive Workforce

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The inspector found that residents’ privacy and dignity was respected by staff. Staff interacted with residents in a courteous and pleasant manner and were familiar with their needs.

Staff files were reviewed and were found to contain all of the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Whilst mandatory training was in place, including training for non nursing staff in the management of medication, there was no evidence of training in meeting some of the particular needs of the residents, for example the management of dysphagia.

While managers described a system of 1:1 staff appraisal with some staff, this was not in place for direct care staff. The operations co-ordinator explained that a process for the introduction of a formal staff appraisal system had commenced, and been piloted in another centre within the organisation.

The inspector was concerned about the number of staff on duty and the skill mix of the staff. There was not always a nurse on duty, and residents in the centre had extensive healthcare needs. Where a nurse took annual leave they were not replaced, which could result in as few as 22 nursing hours in the week. There was no nurse allocated to night duty. It was unclear as to how all the care plans for residents which were not yet in place could be completed with this level of nursing cover.

Staff and residents expressed concerns to the inspector about the number of staff on duty, in particular in relation to the use of the hydropool, which required two staff members, and in relation to the implementation of physiotherapy programmes, which were not conducted as frequently as recommended.

**Outcome 18: Records and documentation**
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational
policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Theme:**
Use of Information

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The medication policy required improvement as referred to in outcome 12. For example there was no reference to the crushing of medications, as required (PRN) medications or the management of confidentiality in relation to the blister packs from which the medication was administered.

Identifying information relating to the resident and the medication were printed on the lid of the blister packs. While staff were observed to wash the identifying information off the lid of the blister packs before discarding, the policy on medication management did not guide staff in this practice.

The inspector was concerned that the prescribed times of administration of medication did not adequately safeguard residents. Times were described as breakfast, lunch, teatime and night time and not identified according to the 24 hour clock which may result in inconsistency of administration times, and inappropriate lengths of times between medications.

There was no policy available to guide staff in the area of nutrition, and no policy on the management of dysphagia, despite the needs of some residents in this area.

There was no written policy on the management of residents' finances.

Where PRN medications were prescribed there was no written protocol available to guide the staff in the decision making process. Where PRN medications had been administered there was no evidence of the time of administration being recorded. The inspector was concerned that this was not safeguarding residents in relation to maximum dose and appropriate times between medications.

Other areas under this outcome were not reviewed during this inspection.
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Julie Pryce
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Cheshire Foundation in Ireland (t/a Cheshire Ireland)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0011353</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>10 April 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>11 July 2014</td>
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</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Most residents did not have a comprehensive assessment of needs.

Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
All residents will undergo a comprehensive assessment of need by the Nursing & trained Care Support staff within the service and a corresponding care plan developed

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Proposed Timescale: 15/08/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Most residents did not have a personal plan.

Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
All residents will undergo a comprehensive assessment of need by the Nursing & trained Care Support staff within the service and a corresponding care plan developed by 15th August 2014. This plan will be reviewed on an annual basis or as required

Proposed Timescale: 30/09/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents were accommodated in an inappropriate building.

Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
One of the people living in the main house will be offered accommodation in the Respite service or the courtyard.
The second person’s accommodation arrangements will be addressed as part of the de-congregation process.

Proposed Timescale: 31/12/2014

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
<table>
<thead>
<tr>
<th>The risk policy did not include all the requirements of the Regulations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<tr>
<td>A Risk Management policy was developed by Cheshire Ireland and is now in place</td>
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<tr>
<td><strong>Proposed Timescale:</strong> 20/06/2014</td>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Individual resident’s risk assessments were not in place.</td>
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<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>A review of all risks will be carried out, and each individual will have any risk assessments required carried out by 31st August 2014 and placed in their files by 15th September 2014. An emergency plan is in place for the service and is reviewed on a regular basis or as required.</td>
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<td><strong>Proposed Timescale:</strong> 31/08/2014</td>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>Fire drills had not been conducted annually.</td>
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<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<tr>
<td>Fire drills are now scheduled within the service on a quarterly basis.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 31/05/2014</td>
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</tbody>
</table>
### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Risk assessments and audits of restrictive practice were not in place.

**Action Required:**
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**
Current policy on restrictive practices is up for review. This review will be completed by the 30th September 2014 by Clinical Manager. Risk assessments will be carried out on all restrictive practices in place by the Nursing Team and will be completed by the 30th November 2014. Audits will be carried out on a quarterly basis by the Nursing Team & trained Care staff commencing September 2014.

**Proposed Timescale:** 30/11/2014

### Theme: Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that all alternatives to restrictive practices had been considered.

**Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
As part of the risk assessment regarding restrictive practices (process outlined above), evidence of alternatives will be documented

**Proposed Timescale:** 30/11/2014

### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no personal plan for the majority of residents against which appropriate health care could be provided.

**Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident’s personal plan.

**Please state the actions you have taken or are planning to take:**
All residents will undergo a comprehensive assessment of need by the Nursing Team & Trained Care Staff under their supervision as appropriate within the service and a corresponding care plan developed by 15th August 2014. This plan will be reviewed on an annual basis or as required.

**Proposed Timescale:** 15/08/2014

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Food and drink offered was inconsistent with residents' preferences at tea time.

**Action Required:**
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident’s individual dietary needs and preferences.

**Please state the actions you have taken or are planning to take:**
Appointing a second qualified chef in September 2014.

Documentation regarding menu planning, choices offered to individuals considering identified preferences and satisfaction surveys to be carried out with residents, commencing July 2014 with a specific focus on evening teas.
Food presentation to be reviewed by Head of Supportive Services to ensure all meals including meals for individuals requiring modified diets commencing July 2014.
Standards around food presentation to be monitored by Service Co-Ordinator commencing July 2014.

**Proposed Timescale:** 31/08/2014

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no action plan in place to address concerns regarding the standard of care and support as identified by the person in charge.

**Action Required:**
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and...
Please state the actions you have taken or are planning to take:
The CEO has delegated responsibility and authority to Cheshire’s Quality Department to undertake unannounced visits to all its designated centres at least once every six months.
A subsequent report will be prepared outlining the safety and quality of care and support provided in the centre and corresponding plan will be developed to address any concerns regarding the standard of care and support
One inspection to take place before 31st December 2014

**Proposed Timescale:** 31/12/2014

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### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The number and skill mix of staff were insufficient to meet the needs of residents.

**Action Required:**
Under Regulation 15 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:
An review of assessment of need to be carried out to 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. This assessment will be carried out by the Clinical Support Services Dept in partnership with the Head of Care & Nursing Care Team and will be completed by 31st October 2014. A subsequent roster review will be carried out by the Service Manager & Head of Care in conjunction with the Human Resources department and any required changes to the current roster to be implemented.

**Proposed Timescale:** 31/12/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff required training in relation to the particular needs of residents.

**Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional
**Please state the actions you have taken or are planning to take:**
A review of all staff training requirements (Based on the residents’ assessments of need) to be carried out by Head of Care, Service Co-Ordinator and training which addresses any gaps identified will be planned by Training Development Manager and Service Co-Ordinator by 31st August 2014

**Proposed Timescale:** 31/08/2014

<table>
<thead>
<tr>
<th>Outcome 18: Records and documentation</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Use of Information</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The medication policy required review to ensure in guides staff in best practice. There were no policies to guide staff in the following areas: the management of nutrition; the management of dysphagia; the management of residents finances.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<tr>
<td>A policy regarding the management of residents’ finances is now in place. Organisation’s Clinical Support Service Department to develop a policy document on the monitoring and documentation of nutritional intake for residents which will be completed by 31st October 2014. Organisation’s Clinical Support Services Department to develop a policy document to guide staff on the management of dysphagia by 31st October 2014. Risk assessments regarding dysphagia now in place. Organisations’ medication management policy is currently under review by the Clinical Support Services Department. This review will be completed by 31st October 2014.</td>
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<tr>
<td><strong>Proposed Timescale:</strong> 31/10/2014</td>
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<tr>
<td><strong>Theme:</strong> Use of Information</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>Records as required in Schedule 3, 3.(h) as relates to medication management were incomplete.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.</td>
</tr>
</tbody>
</table>
Please state the actions you have taken or are planning to take:
All documentation required within Schedule 3 will be reviewed, gaps identified and documentation collated/developed by Office Administrator by the 30th November 30th 2014

Proposed Timescale: 30/11/2014