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:	09 February 2026
Centre ID:	OSV-0003441
Fieldwork ID:	MON-0048644

About the designated centre

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

Cara Cheshire Home is a designated centre operated by The Cheshire Foundation in Ireland. The centre provides support to adults with primarily physical disabilities and/or neurological impairments. The centre is set on extensive grounds set in park lands, located near Dublin city centre and other amenities. The centre is registered to provide support to 11 people, each with their own individual bedroom. The service has a large dining room, a laundry, kitchen, an activities room, domestic kitchen, TV room, office spaces, a large sitting room, a sun room, landscaped grounds, and a patio area. 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 and administrators.

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
Monday 9 February 2026	08:00hrs to 16:00hrs	Jennifer Deasy	Lead
Monday 9 February 2026	08:00hrs to 16:00hrs	Orla McEvoy	Support

What residents told us and what inspectors observed

This inspection was an unannounced follow-up risk inspection. It was carried out subsequent to an inspection of the designated centre in September 2025 where high levels of non-compliance were found.

This inspection aimed to monitor the provider's progress in implementing the actions detailed in their compliance plan, submitted to the Chief Inspector following the September 2025 inspection, and to assess if there had been improvements in compliance. This inspection found the provider had implemented their compliance plan actions which were having a positive impact to residents.

The designated centre is located in park lands close to Dublin City Centre and is home to 11 residents. lt is a single storey building which has recently undergone significant refurbishment works to enhance the facilities and to ensure the accessibility for the residents, many of whom use mobility aids.

Inspectors met with six residents who were in the centre on the day of inspection. Inspectors did not meet with the residents who were self-isolating due to suspected respiratory infections. Some residents chose to speak with inspectors in detail about their experiences of living in the centre. Inspectors used conversations with residents and staff members, observations of care and support and a review of documentation to inform decision-making on the quality and safety of care.

Inspectors observed the morning routine of the centre. There were sufficient staff on duty to ensure that residents' needs were met in a person-centred manner and in a way that upheld their privacy and dignity. The pace of the morning was relaxed and staff were seen to communicate with residents in a respectful manner. Staff members were observed knocking before entering residents' bedrooms and ensuring that bedroom and bathroom doors were closed when providing personal care.

There was information available for residents, in an easy to read format, regarding the activities on offer and on advocacy and human rights.

Inspectors sat with two residents during their breakfast. One of these residents communicated through gestures, facial expression and vocalisations. A staff member, who was supporting the resident with breakfast, asked for the resident's permission to assist them with communicating with the inspector. The staff member was found to be very knowledgeable regarding the resident's communication system and responded to their gestures and vocalisations. For example, the resident pointed to their watch and then waved their hand over their breakfast. The staff member enquired if the resident was finished and wished to go, and the resident confirmed that this was what they wanted.

This same staff member told the inspector that they had completed training in a human rights based approach to care. They told the inspector of how they ensured that residents had choice and control in their daily lives; for example they described spending time with a resident who had recently moved in to the centre and getting to know them and understand how the resident communicates and makes choices.

Another resident, who had recently moved to the centre, spoke to the inspector about their interests and routines. When asked, they explained that their main activities outside the centre involved engaging with services offered by community-based organisations. They also spoke about their keen interest football and shared how staff support them to maintain this interest and provide assistance to set up matches on their television. They shared their goal of travelling to the UK to watch a game. On review of this resident's key worker meeting notes, the inspector subsequently saw that the resident was supported to organise a television and subscription to maintain this interest. Their goal to travel to a match was also being explored.

During the conversation, the inspector saw that this resident appeared startled by doors banging outside the dining room. These doors were used frequently during the inspector's conversation. Managing this background noise while having a conversation appeared effortful for the resident. It was subsequently noted that this resident's communication plan recommended a quiet environment. This resident was dependent on staff for mobility. When asked how they alert staff when assistance is needed, they showed the inspector a wearable wrist button which alerts staff to their need for assistance. Staff explained that a referral had been made to explore mobility options to enhance the resident's independence.

Inspectors met with another resident who communicated using an individualised eye movement system. This resident, with the assistance of staff members, told the inspector that they were satisfied that the "majority" of staff could support their communication. They told the inspector that they had a high tech communication system but that they preferred to use their own eye movements with staff. The inspector saw that there were staff on duty who understood the resident's communications.

Inspectors observed staff donning and doffing personal protective equipment (PPE) to support the two residents who were self-isolating. There was sufficient PPE available in the centre and staff were seen using gloves, aprons and FFP2 masks when entering residents' bedrooms. However, improvements were required to the arrangements for donning and doffing of PPE, including to the hand hygiene and disposal facilities. For example, there were no hand towels available in the donning room for staff to wash their hands before putting on PPE. Additionally, it was directed through signage that the donning room was to be a "clean room" and no used PPE was to be in that room; however, inspectors saw used PPE in two of the disposal bins in this room.

Overall, inspectors saw that the provider was implementing their actions as detailed in their compliance plan and were endeavouring to enhance their oversight. Residents were seen to be comfortable and happy in their home, although one

resident was startled by the banging of doors in the busy environment. However, there remained gaps in oversight, as evidenced in particular by the IPC risks identified on this inspection. Additionally, the lack of a readily available multidisciplinary team meant that some residents were awaiting assessments and interventions which was impacting on their well-being.

The next two sections of the report will describe the governance and management arrangements of the centre and how effective these were in ensuring the quality and safety of care.

Capacity and capability

This section of the report describes the oversight arrangements of the centre and the impact that these had on the quality and safety of care. This inspection found that residents were being supported by a consistent staff team who had access to an ongoing programme of training and who were supervised and performance managed. The provider had implemented several strategies to enhance their oversight of the centre; however, there remained areas for improvement in respect of the management systems, to ensure that these were effective in monitoring the safety of the service.

The designated centre was staffed by a team of healthcare assistants, social care workers and staff nurses. The staffing complement had been enhanced recently by the employment of additional staff members, including drivers, who could facilitate residents to access the community. Staff members had access to a training and development programme to ensure that they maintained their competence in relevant areas. There were some minor gaps in respect of refresher training identified on this inspection and, in particular, improvements were required to staff training in modifying fluids.

Staff members spoken with understood their roles and responsibilities and were familiar with the reporting lines. Staff members were in receipt of formal supervision and told the inspectors that they felt well supported in their roles.

There were clearly defined management systems which stipulated accountability and roles and responsibilities. The internal management structure was appropriate to the size of the service. Since the last inspection, there had been changes made to the management arrangements to improve communication and ensure that the person in charge had oversight of the quality and safety of care. For example, the person in charge now attended regular meetings with the provider's clinical lead and with other local managers of the service.

Improvements were required however to the management systems to ensure that the service was being operated in a manner which used best available evidence to ensure the safety of care for the residents. Deficits were identified in respect of the

provider's and the local management team's response to an outbreak of infection. The management team were not implementing the current guidance on managing outbreaks in residential facilities. This posed a risk to the wellbeing of residents. Additionally, the provider's audits had not identified numerous infection prevention and control (IPC) risks within the service.

Improvements were also required to the provider's oversight of restrictive practices. The person in charge had implemented systems locally, subsequent to the last inspection, to enhance oversight of restrictive practices but it was not clear, from the provider's policy, how the provider intended to monitor and review restrictive practices within it's designated centres.

Regulation 16: Training and staff development

A training matrix was maintained within the centre which showed that staff members had access to refresher training as required.

There was generally a high level of compliance with mandatory and refresher training, however some staff were overdue refresher training in specific areas, including:

- 4 staff required refresher training in managing behaviour that is challenging
- 2 staff required refresher training in safeguarding vulnerable adults
- 3 staff required refresher training in Children First
- 2 staff required refresher training in AMRIC hand hygiene
- 7 staff required refresher training in the National Standards in IPC measures in community settings.

Staff training in relation to one resident's feeding, eating, drinking and swallowing required enhancement. Staff had received training from other healthcare staff as part of the admission process for this resident; however, inspectors found that this training did not wholly inform staff of the correct procedures for modifying fluids as staff were, for example, unfamiliar with techniques to test the fluid to ensure that it was at the correct consistency.

Inspectors spoke with several staff members about the training and supervision supports available in the centre. Staff members told the inspectors that they had received training in human rights and described how this informed their practice. This is discussed further under Regulation 9 Rights.

A staff member told the inspector that they receive quarterly one to one supervision and that they were comfortable raising any concerns to the management team. They said that senior staff members also attended staff meetings every six weeks which provided an additional forum to discuss pertinent issues with managers relating to areas such as care plans and staffing.

Judgment: Substantially compliant

Regulation 23: Governance and management

This inspection found that the provider was implementing the actions as outlined in their compliance plan received subsequent to the September 2025 inspection in order to improve the quality and safety of care of the service. For example, the provider had completed an additional six monthly review of the service in January 2026 which had reviewed the risks presenting in the service and implemented an action plan to address deficits. This review was completed by the head of the provider's clinical and quality service.

There were enhanced meetings in order to ensure that the person in charge had oversight of risks. For example, the person in charge and clinical nurse manager 1 (CNM1) now had meetings every six weeks with the provider's clinical lead in order to review resident's care plans. The person in charge now also attended the nurses meeting to ensure they were kept informed of residents' nursing needs.

The centre was adequately resourced and staff were performance managed. There were clearly defined management systems. The staff team were supervised and supported by a CNM1 and service co-ordinator, who in turn reported to the person in charge. However, there were deficits identified in the local and provider level management arrangements which required improvements. For example, while there was an IPC lead in the centre, who had completed IPC link practitioner training, there were numerous IPC deficits identified on this inspection which had not been identified and controlled for. These deficits, including the lack of an up-to-date outbreak management plan, had not been identified through the provider's audits.

The inspectors were told that the the managers of the centre had sought guidance from the provider in respect of managing an IPC risk however they were provided with incorrect advice. Senior managers were not informed regarding the current guidance on managing outbreaks of infection in residential care facilities. This is discussed further under Regulation 27.

Additionally, while the provider had a policy in place in respect of restrictive practices, further detail was required to outline the systems in place to ensure that the provider had oversight of restrictive practices used in their service. This is discussed further under Regulation 7.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The provider had an up-to-date admissions policy. The inspectors were told that contracts of care were now all easy to read or written in Plain English and that each resident had an up-to-date contract of care on their file. The inspector reviewed two contracts of care and found there were up to date and presented in an easy to read or plain English format.

Judgment: Compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents who lived there. Overall, inspectors were told by residents that they were happy living here and that they felt well-supported by the staff team. Inspectors found that the provider had implemented actions, as detailed in their previous compliance plan from the inspection in September 2025, to enhance the quality of care. In particular, improvements were seen in respect of supporting residents' communication, ensuring access to public health screenings and upholding their human rights. There were deficits identified in respect of the infection prevention and control (IPC) arrangements of the centre.

The inspectors reviewed three of the residents' files in detail and saw that each resident had an individual assessment which had been updated. Care plans were implemented in respect of residents' assessed needs. In particular, improvements had been made to residents' communication care plans and inspectors were told by residents that staff members understood and could support their communication. Inspectors saw that residents were listened to with care and respect by staff and were facilitated to exercise their views and opinions.

Residents had been supported to attend their general practitioners and to seek referrals to public health screenings. Residents were provided with information about their healthcare needs and their consent was obtained in respect of referrals and healthcare assessments.

The provider and person in charge had reviewed restrictive practices in the centre. This review resulted in the elimination and reduction of many restrictive practices. Where restrictive practices were in place, there was clear rationale for these and residents' consent was obtained. While the oversight of restrictive practices at local level had improved, it was not evidenced how the provider intended to monitor and audit restrictive practices in order to implement a reduction strategy.

Inspectors found that there were policies and procedures to ensure that residents were protected from abuse. Allegations of abuse were dealt with in an effective manner and were reported to the required statutory authorities.

Staff members had received training in human rights and told inspectors of how they ensured residents' rights to privacy, dignity and autonomy were maintained. The local management team had implemented changes to endeavour to further uphold residents' rights. These changes included introducing more varied options for evening meals and enhancing the number of drivers available. Extra staffing resources had been allocated to the centre to facilitate evening entertainment.

The person in charge told inspectors that the provider was in the process of contracting private multidisciplinary professionals to support the accurate assessment and ongoing review of residents' needs and to inform their care plans. However, at the time of inspection the available multidisciplinary support was insufficient and inspectors found that there were gaps in residents' assessments and care plans which posed a risk to their safety and wellbeing. For example, one resident's had not received an appropriate assessment in respect of mobility aids and was reliant on staff members to mobilise.

Improvements were required to the policies and procedures for the management, review and evaluation of outbreaks of infection. There were numerous IPC risks identified on this inspection which posed a risk to the safety and wellbeing of residents. These risks related to the implementation of both standard and transmission based procedures.

Regulation 10: Communication

Inspectors saw that residents who required support with their communication had received a review from an allied health professional subsequent to the last inspection of the centre. Two of these residents' files now contained an up-to-date communication care plan to guide staff in supporting their communication needs.

The inspector met one resident who communicated using gestures and vocalisations. They were being supported with their breakfast by a staff member. The inspector observed respectful interactions between the staff and the resident. The staff member asked for the resident's consent to assist them with communicating with the inspector and clearly understood the resident's non-verbal communication.

The inspector also met a resident who communicated using an individualised eye movement system whereby they used eye movements to spell words. The inspector saw that there were staff on duty who understood this resident's communication system and who could assist the resident to communicate with the inspector. The resident told he inspector that the "majority" of staff understood their communication. They told the inspector that they had a high technology communication device in their room but that they preferred to use their eye movement system.

Judgment: Compliant

Regulation 27: Protection against infection

Inspectors were told, on arrival to the centre, that two residents were in hospital with respiratory infections and that a further two residents were self-isolating for 48 hours due to respiratory symptoms. Inspectors enquired about the IPC arrangements for managing outbreaks of infection and found that these were not in line with the relevant guidance. Senior staff members spoken with were not informed of IPC guidance documents for residential facilities and instead were using general public health guidance. The following failures in respect of implementing relevant guidance were identified:

- multiplex (PCR) testing for both COVID-19 and influenza had not been completed for symptomatic residents
- residents were advised to isolate for 48 hours rather than 5 days
- there was no signage on symptomatic residents' doors to indicate that transmission based precautions were required.

Inspectors observed a number of IPC risks in respect of staff practices and the facilities of the service. These included:

- several bins were broken and did not close properly, including those used to contain used personal protective equipment (PPE)
- a room designated as a "clean room" to don PPE had a sink with soap but there were no hand towels available. Staff were observed to put on PPE without first washing their hands
- two bins in the "clean room" contained used PPE in spite of signage which directed that no used PPE was to be in this room
- numerous laminate counter tops were damaged and so could not be cleaned effectively including the counter top in the "clean room" and in the dining room
- PPE signage/information leaflets were not appropriate to the service; for example, a PPE donning information leaflet displayed in the clean room outlined guidance for PPE required in an operating room
- an open tub of butter was stored underneath the hand towels in the dining room. This posed a risk of contamination of food stuff for the residents

The centre's outbreak management plan was last updated in 2023. There was no up-to-date outbreak management plan to provide guidance to staff members in managing outbreaks of infection in line with current guidance and best practice.

Overall, there were numerous IPC risks which posed a risk to the safety of the residents. The provider convened an emergency outbreak meeting on the day of inspection and implemented additional protocols to protect residents including, for example, asking residents to self-isolate for 5 days rather than 48 hours.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed three of the residents' files which contained their individual assessments and care plans. Inspectors saw that each resident had an individualised assessment which detailed their health and social care needs. Care plans were implemented in respect of needs to guide staff. The inspector reviewed three support plans and found them detailed and personalised to the preferences of each resident. For example when being supported with personal care, one care plan noted that "I like some conversations while getting up and for staff to turn on the TV". Other plans outlined residents' preferences when getting dressed, for example how and in what order to put clothing on. Plans were accompanied by risk assessments where necessary and support plans were in place for identified issues.

However, improvements were needed to ensure that support plans were informed by the recommendations of health and social care professionals where needed to maximise the independence of residents, enhance their quality of life and manage risks. Some residents were waiting input from allied health professionals. The inspectors were told that the provider was in the process of contracting private allied health professionals to inform the assessments and care plans.

The impact of the lack of readily available health and social care professionals was that residents' needs were not being met in a timely manner. One resident, who had been recently admitted to the centre, was dependent on assistance from staff to move around the designated centre. The provider had made a referral to a seating service to explore mobility options to enhance their independence. The resident remained dependent on staff to access his environment freely until this assessment was completed.

Where assessments were completed by allied health professionals, improvement was needed to integrate the assessment process to ensure it was informed by the residents' preferences and to include staff perspectives on the effectiveness of the care plans and recommendations made. For example, one resident's feeding, eating, drinking and swallowing (FEDS) assessment did not incorporate some of the resident's preferred food choices. A staff member spoken with told the inspector that, on occasion, this resident may choose to eat foods which are outside of their recommendations. The staff member was not part of the recent review of the residents' FEDS care plan and therefore did not have an opportunity to discuss this with the allied health professional. For this reason, there was an absence of guidance in the care plan on how staff should manage this risk.

There were some inconsistencies between residents' care plans and observations on the day of inspection. The inspector observed that the resident was supervised during eating. This was not documented in the care plan. One resident's

communication plan recommended a low level noise environment. A frequent loud noise in the dining room impacted on the resident's conversations.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner and the staff team included registered nurses. The inspector saw that residents had follow up appointments with medical specialists. Residents also had access to community health supports such as chiropody, optometry and audiology services.

The residents were assisted to participate in the national preventative health screening programme through a review with their GP.

Some residents had needs related to maintaining skin integrity. All staff had completed training in Maintaining Skin Integrity. The provider had a policy for the Prevention and Management of Pressure Ulcers and Moisture Associated Skin Damage. The inspector reviewed two care plans related to skin integrity and found each of them to be in line with the provider's policy and provided sufficient detail to guide staff. Where needed, the provider had identified additional actions to ensure residents' skin integrity needs were maintained.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had reviewed the restrictive practices in the centre subsequent to the last inspection. They had been supported in completing this review by the provider's clinical lead. The review resulted in the elimination or reduction of some of the restrictive practices; for example, night checks had been removed for all residents with the exception of one. Where restrictive practices were implemented, there was a clear rationale for them and residents' consent was obtained. The person in charge had implemented systems to ensure ongoing monitoring of restrictive practices at local level; for example, through quarterly rights restriction and restraints reviews being completed.

However, improvements were required to the oversight of restrictive practices at provider level. For example, the restrictive practices policy detailed that "Cheshire Ireland will seek to put structures in place to ensure it is aware of restrictive practices in their service" and that "...restrictions are in compliance with regulations and national standards". However, the policy did not define how this was to be achieved and, in speaking with local managers, they were not aware of any provider

level restrictive practice committee. The inspector was told later that there was a provider level committee and that this committee met quarterly and reviewed restrictive practices; however, it was not demonstrated that this committee was being utilised by the service and that there was regular review and oversight of restrictive practices by the provider.

Judgment: Substantially compliant

Regulation 8: Protection

There were two recent safeguarding incidents identified in the centre. The inspectors reviewed the documentation maintained in respect of these incidents. It was seen that both were reported to the relevant statutory authorities and that safeguarding plans were implemented in order to protect the residents.

An inspector spoke with a staff member in detail regarding their safeguarding roles and responsibilities. They told the inspector that they had completed training in Safeguarding Vulnerable Adults. They were informed of how to report safeguarding concerns and of steps to take to ensure the safety of residents.

Residents' files also contained up-to-date intimate care plan which detailed their preferences in respect fo their personal care.

The Schedule 2 files of three staff members were reviewed and were found to contain all of the information as required by the Regulations, including an up-to-date Garda vetting record for each staff member.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had enhanced the measures in the centre to ensure that residents' rights were being promoted. The majority of staff in the centre had completed training in human rights by the time of the inspection. The inspectors spoke with a number of staff about this training and the impact that it had on the care and support that they provided to residents. One staff member told an inspector that they make sure to offer residents choices and support their communication. They described ensuring residents' privacy and dignity was upheld in respect of their personal care. The provider had implemented a local rights checklist to be used with staff members at quarterly supervision sessions to continue to support them to understand their responsibilities in respect of upholding residents' rights.

A weekly activity schedule was on display. This included daily activities across seven days of the week, including a sing along, arts and crafts, a quiz and bingo. Evening

activities had been introduced and were available on three evenings comprising of a book club, karaoke and a movie night. The provider had rostered on additional care staff to facilitate these evening activities.

The routine around the night time snacks had been changes. A trolley was no longer brought to residents' bedroom with set snacks. Instead staff members had access to the domestic kitchen to prepare meals and snacks for residents if they wanted them.

There were sufficient staff seen to be on duty on the day of inspection in order to meet the residents' needs and provide care and support in an individualised manner. The provider had enhanced the number of drivers employed in the centre in order to facilitate residents to avail of increased community activities. Three new staff had started working in the centre, all of whom could drive the centre's vehicles. The inspectors were told that approximately 50% of front line staff could now drive the vehicles.

The inspector reviewed notes from key worker meetings with one resident. These explored resident goals and had evidence that goals were being progressed. Resident rights, safeguarding, health needs, activity preferences and contact with friends were discussed.

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 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cara Cheshire Home OSV-0003441

Inspection ID: MON-0048644

Date of inspection: 09/02/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff instructed to carry out online mandatory training on time and sent reminder emails before due date. Regular reviews of training matrix carried out by management. • 4 staff required refresher training in managing behaviour that is challenging. Completed. • 2 staff required refresher training in safeguarding vulnerable adults. Completed. • 3 staff required refresher training in Children First. Completed. • 2 staff required refresher training in AMRIC hand hygiene. Completed. • 7 staff required refresher training in the National Standards in IPC measures in community settings. Completed. Staff training in relation to one resident's feeding, eating, drinking and swallowing required enhancement. Training with private SLT took place on the 10/03/2026.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Infection prevention control measures have been enhanced in the service. Service to complete an additional IPC audit before the end of March and review same with the	

regional clinical partner to identify deficits in place. Local management team will also conduct a review of IPC training and prioritise same to address compliancy with IPC policy.

• In service IPC link practitioner (CNM1) has commenced conducting local information sessions on IPC with care support staff to address any gaps in staff knowledge. Notification in place on service care management system (IPlanit) to direct staff to updated organizational IPC and outbreak policies – checks of staff knowledge and awareness of same will be conducted.

• Full outbreak management plan in place following outbreak of ARI, actions for same discussed in Regulation 27. Debrief meeting held after closure of outbreak identifying areas of further improvement and service learning for future outbreaks/practice.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

• Outbreak management meeting held on 09/02/2026 with local management team, regional manager and regional clinical partner. Outbreak was officially closed by Public health following consultation on 25/02/2026 and outbreak closure meeting held with local management team, regional manager and Head of clinical services to gain insight into issues/ failures identified at onset of outbreak. Policy on Management of outbreak for Covid/flu/ARI and IPC updated.

• All updated policies are in place and available on Intranet with Local clinical team providing guidance on changes through local team information sessions.

• Local IPC management folder has been updated with case management information and contingency plans updated with current guidance including guidance on isolation for symptomatic staff/ residents and guidance/ resources for further outbreaks including relevant signage.

• Local clinical team have plan in place with GP to access where possible Multiplex PCR swabs or Covid/Flu swabs as per HSPC guidance.

• All pedal bins in high traffic areas such as the corridors have been replaced to ensure compliance with IPC guidance with new pedal bins on order for residents' bedrooms.

• Bin usage will be discussed at local team meetings to ensure that staff are aware and compliant with IPC guidance especially regarding disposal of PPE.

• Local management reviewed the clean room layout in line with the outbreak and changes to layout have been made including increased signage for handwashing and PPE usage. Hand towel dispensers have been installed, and work lists have been amended to ensure that they are serviceable at all times.

• Service has increased hand hygiene audits across the service and all staff will be audited at least twice throughout the year. Hand hygiene signage has been reviewed and reinstalled at all areas where handwashing is available. Hand hygiene will be discussed regularly in local team meetings.

• All laminate counter tops have been reviewed and plan to address the replacement of same in place.

• A full IPC audit will be completed by the end of March 2026 with the regional clinical partner to identify all areas of IPC risk not previously outlined in H2 audit 2025 and in line with organizational audit guidelines.

• Hand towel unit is moved from the food preparation area in the dining room (27/02/26). Food preparation staff will ensure that all food supplies are covered when not in use and away from any contaminants.

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:

• Meeting with HSE to discuss MDT arrangement with St Mary's Hospital took place 04/03/2026. Outcome: MDT arrangements being reviewed but assured that MDT support would recommence.

• Private SLT and OT hired by service. A swallowing assessment was carried out on 24/02/26 for resident that uses Nutilis and care plan updated. OT is available if there is any review needed.

• Training for use of Nutilis thickener for staff by SLT carried out on 10/03/26. Training covered the preparation of fluids in line with IDDSI framework and resident's support plan.

• Support plans updated under the eating and drinking section on service care management system (Iplanit), plans identify the level of supervision while having meals in the dining room for those requiring assistance.

• Referral for new power chair for new resident sent to CRC (05/01/26). CRC has

accepted the referral and awaiting additional information before assessment. Service has received confirmation of the same and will follow up with CRC while awaiting an appointment.

• Maintenance has conducted a review of the access/egress point identified by inspectors, issue was listed for maintenance review and same completed on the day of inspection (09/02/26).

• Nutilis thickener moved from the dining room to medication trolley on the day of inspection (09/02/26). Staff advised to access it from the medication trolley in the care office and return when finished using it, to avoid accidental ingestion by any residents. Support plans updated with information on where to access same for staff.

• Resident with preferred food choices advised to follow the SLT guidelines. Resident was reviewed by the private SLT on 10/03/2026 with keyworker present. Resident stated he now follows the SLT guidelines regarding diet when in the service and also when he eats out.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• The Policy on the Use of Restraints and Restrictive Practices will be reviewed to ensure the processes that are in place to ensure effective governance and oversight are clearly outlined and can be easily referred to by service management.

• All restrictive practices and restraints in use/ or those that have been discontinued to be discussed at the local management operations meeting.

• The service conducts a quarterly restrictive practice audit.

• The service restrictive practice register, and audit will be reviewed at the quarterly service regional support services meeting attended by service management, the regional manager, the regional clinical partner and the regional quality partner.

• Regional audit compliance rates are reviewed by the National Clinical Lead who monitors for trends and reports into the national QSRM Sub-Group.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/03/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2026
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare	Not Compliant	Orange	30/04/2026

	associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2026
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	31/03/2026
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a	Substantially Compliant	Yellow	31/03/2026

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/03/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/06/2026