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:	08 September 2025
Centre ID:	OSV-0003441
Fieldwork ID:	MON-0048091

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:	10

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 8 September 2025	18:40hrs to 20:30hrs	Jennifer Deasy	Lead
Tuesday 9 September 2025	09:30hrs to 17:15hrs	Jennifer Deasy	Lead
Monday 8 September 2025	18:40hrs to 20:30hrs	Kieran McCullagh	Support
Tuesday 9 September 2025	09:30hrs to 17:15hrs	Kieran McCullagh	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out in response to receipt of solicited information received by the Office of the Chief Inspector.

The inspection was completed by two inspectors and took place over the course of one evening and the following day. Inspectors had the opportunity to meet with all of the residents living in the centre. Some residents chose to speak with inspectors in detail about their experiences of living there. Inspectors used conversations with residents and staff along with observations of care and support and a review of documentation to inform judgments on the quality and safety of care in the centre and compliance against the regulations.

The designated centre is located in park lands close to Dublin City Centre. The designated centre is resourced with five resident transport vehicles to facilitate the 10 residents to access the community. However, inspectors were told by both staff and residents that there were an insufficient number of staff that could drive the centre's transport vehicles and that this was impacting on community access. One resident told inspectors that sometimes there were disagreements between residents over who got to go out. The person in charge told inspectors that the number of staff that could drive the transport vehicles had reduced by three in recent times and this was something which the provider was endeavouring to address.

The centre is a large purpose built building, designed with four main corridors. The provider had completed upgrade works to the premises, as required by a non-standard condition on their previous registration. These works reconfigured the building and resulted in the relocation of administration offices to one wing of the building, among other works. The aim of this was to make the centre more homely in layout and design.

Residents were provided with a large television room, shared accessible bathrooms, and accessible kitchen and two activities rooms. Residents' bedrooms were personalised and were equipped with aids such as medical grade beds, pressure relieving mattresses and ceiling mounted hoists, if required. To enhance accessibility arrangements in the centre, residents' bedrooms had also been recently equipped with automatic doors which opened when residents used a keypad or switch. Many of the residents had large televisions in their bedrooms and one resident had an augmentative communication device.

Residents in this centre shared the centre's canteen and dining room facilities. Food was provided by a chef and was prepared in line with residents' assessed needs. Inspectors were told that the chef consulted with residents about meal choices on a regular basis. Residents were seen being supported by staff with their meals. Staff and resident interactions were seen to be familiar and respectful. There were

sufficient staff available to assist residents with meals and residents communicated to inspectors that they enjoyed the food provided in the centre.

When inspectors arrived on the first evening of inspection at 6:40pm they were greeted by a resident and a staff member. Inspectors asked if the resident, who had greeted them, and staff on duty could show them around and explained to the service coordinator that they would be back the following day to review documentation. The resident agreed to show one inspector around and a staff member showed the second inspector around the centre.

Inspectors met two residents who were up and about in the communal areas of the centre. One resident was watching television in the main sitting room and the other resident assisted with showing inspectors around and then chatted to staff. A third resident had gone out with their family for the evening to celebrate their birthday. The other seven residents were in their bedrooms; three residents were in bed, one resident was being assisted with a meal and the other three residents were watching television or relaxing in their rooms.

Inspectors saw, and were told, that it was residents' choice to retire to their rooms or go to bed at that time of the evening. Staff members told inspectors that residents regularly went to shows, concerts and out to movies however evening activities had to be planned up to a week in advance in order to ensure there were sufficient staff and drivers were available.

Inspectors greeted most of the other residents, who were in their bedrooms, some chatted to inspectors briefly and others chose not to engage with inspectors, as was their choice.

One resident, who showed inspectors around, told inspectors said that they were happy living in the centre but that ultimately they would like their own place. They said that they had talked to the person in charge about this. The resident said that they liked going out for dinner and had a good friend who was also a resident in the centre. The resident knew who they could talk to if they had a complaint. They said that they were looking forward to a social event which was planned for the coming weekend in the centre.

A second resident, who was watching television, communicated through non-verbal means. The inspector asked the resident and staff if there was a communication support system available to support their conversation. The inspector was told the resident did not have one in place, therefore the inspector asked yes and no questions and, through this manner, the resident indicated that they were happy and that they liked watching television in the evenings.

Inspectors met another resident who communicated using eye movements and an augmentative device. The staff member supporting the resident was very skilled in understanding the resident’s communication system. However, not all staff members working in the centre were trained in using this system.

Inspectors had the opportunity to speak with a number of staff on duty on the evening of the first inspection day. Through these conversations, inspectors found

that some of the practices being implemented in the centre were contributing to an institutional style of care and support and required further consideration. This is discussed further under Regulation 9: Rights.

The following day, inspectors attended the centre and had the opportunity to meet with the person in charge and clinical nurse manager, as well as other staff on duty.

Five of the residents were in the centre on the second day when inspectors arrived. The other five residents had gone out to day services or clubs. Inspectors saw that many of the five residents who were in the centre preferred a more relaxed pace of life.

One resident watched television for most of the day and inspectors saw that staff sat with the resident and chatted with them at different times during the day. A resident told inspectors that they planned to go to a polytunnel to engage in a hobby which they enjoyed. Another resident told inspectors they were looking forward to going shopping the following day. They said that they regularly went shopping on a Wednesday and it was an outing that they really looked forward to. The remaining residents greeted inspectors but chose not to engage with inspectors as was their choice.

Inspectors spoke with a number of staff, including an activities coordinator and the person in charge, regarding the activities on offer in the centre. Inspectors were told that various activities had been offered and residents had been encouraged to engage in skills development such as cooking, and in group activities such as bingo. However, inspectors were told that many residents enjoyed a particular routine and were not interested in these particular activities.

Overall, the inspection found that residents were living in a warm, safe and comfortable home but that improvements were required to the oversight arrangements and, in particular to the oversight of individual assessments and care plans. A review of some institutional type practices also required consideration to ensure a rights based approach to care was being implemented at all times.

The following section of this report will focus on how the management systems in place are contributing to the overall quality and safety of the service provided within this designated centre.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

The provider had put in place defined management arrangements and systems. Managers of the centre had clear roles and responsibilities. However, some

management systems were not wholly effective in ensuring the quality and safety of care. Improvements were required to ensure that the provider's own policies and procedures were adhered to, and to ensure that provider level audits were effective in driving service improvements.

Staff working in the centre were permanent staff and there were no agency staff used. This was effective in ensuring continuity of care for residents. The staff team was complemented by an activities coordinator who worked with residents to explore personally meaningful activities. The staff team reported to a service co-ordinator, a clinical nurse manager and the person in charge. Each of these managers had defined responsibilities for specific aspects of service provision.

Inspectors found that there were areas of good practice in the service in respect of the oversight of care. For example, local audits included in-person hand hygiene audits and quarterly pressure ulcer audits. Improvements were required to ensure that the provider's policies and procedures were adhered to in practice in the centre. this is discussed further under Regulation 24: Contracts of Care and Regulation 9: Rights.

Provider level audits, such as six monthly unannounced visits, and an annual review of the quality and safety of care were completed in a timely manner and identified areas for improvement. However, enhancements were required to ensure that they effectively identified gaps in compliance with regulations and put in place plans to address these. For example, this inspection found deficits in some areas which were not identified through the provider's auditing and oversight systems.

The provider had ensured that all staff who worked in the centre had received mandatory training in areas such as fire safety, and safeguarding. A review of the staff training records evidenced that staff who required refresher training in positive behaviour support had already been booked to complete this in September 2025. Additional training was provided to staff to support them to safely meet the support needs of residents including various aspects of infection prevention and control, and specific healthcare requirements.

Regulation 16: Training and staff development

Systems were in place for recording and regular monitoring of staff training. While training records were not available in the centre on the days of inspection, a senior manager for the centre provided copies of the training records the day after the inspection for inspectors to review.

A review of the training records confirmed that all staff had completed a comprehensive range of training courses, ensuring they possessed the necessary knowledge and skills to effectively support residents. This included mandatory training in critical areas such as fire safety, and safeguarding vulnerable adults,

indicating strong compliance with regulatory requirements. The majority of staff members had completed training in positive behavioural supports with six staff members booked in to complete this training on 17 September 2025.

In addition to the above and to enhance quality of care provided to residents, further training was completed, covering essential areas such as infection prevention control (IPC), bowel care, managing skin integrity, urinary care, first aid, and Percutaneous Endoscpoic Gastrostomy (PEG) tube care and maintenance.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management systems in the centre however, it was not demonstrated that these were wholly effective in ensuring the quality and safety of care for the residents. Inspectors found that there were inconsistencies in the adherence to provider's policies and protocols and that there were gaps in regulatory compliance which were not being identified by the provider.

The provider had in place a series of audits including six monthly unannounced visits and an annual review of the quality and safety of care. The annual review was completed in consultation with residents and detailed that residents were, for the most part, satisfied with the care and support that they received.

The provider's six monthly audits explored compliance with the regulations but inspectors found that they did not identify gaps in regulatory compliance which were found on this inspection, or disparities between the provider's policies and procedures and actual practices implemented in the centre. For example, the provider's audits had not identified gaps in healthcare screening provisions and the absence of assessments and associated care plans by multidisciplinary professionals for some residents' health and social care needs.

There had been a reduction in the number of qualified drivers working in the centre. This in turn was impacting on the residents' opportunities to avail of the transport provisions for the centre. The provider was required to review the resource arrangements in place to ensure the centre was operating effectively in line with residents' needs and preferences.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Improvements were required to ensure that enough assistance was made available when needed for all residents to meaningfully engage with the processes involved in understanding, agreeing to and signing their contract of care.

Each contract of care reviewed stated "If the person cannot sign the agreement, a person nominated by them (who cannot be a staff member of or connected to Cheshire Ireland) can witness the agreement". However, of the ten contracts of care reviewed during this inspection, a staff member or resident's keyworker had signed the contract on behalf of the resident on all contracts. This was not in line with the provider's policy and procedure relating to contacts of care.

The provider had failed to ensure the information in residents' contracts of care was made available to residents in a format that they could understand to support their informed decision-making on the terms of their contract. Contracts of care referenced there were easy-to-read versions available for residents to use in order to fully understand the terms and conditions being set out. However, there were no easy-to-read contracts signed by residents or on file for any of the residents on the day of this inspection.

Inspectors were provided with a sample copy of an easy-to-read contract of care to review. However, it was not written in plain language and was difficult to follow and understand.

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all monitoring notifications were submitted to the Chief Inspector in line with the three day time frame requirement as set out in the regulations.

Six notifications were submitted within the last 12 months which were outside of the required three day timeframe. These notifications were submitted between five and seven days after the incident.

There were restrictive practices in place which had not been identified as such and reported to the Chief Inspector on a quarterly basis as required by the regulations. These included night checks on residents and a cigarette restriction for one resident.

Judgment: Not compliant

Quality and safety

This section of the report provides an overview of the quality and safety of the service provided to the residents living in the designated centre.

The provider was endeavouring to support residents in a person-centred manner which upheld their autonomy. This inspection found areas of good practice in relation to medication management and protection.

However, improvements were required to the communication supports available to residents, and to their care plans, to ensure that residents were provided with education and support to make informed decisions about their health. Some practices, which could be deemed institutional in nature, also required review and consideration.

The provider and person in charge were striving to ensure residents were provided with appropriate care and support that gave them opportunities to enjoy a good quality of life.

The provider had systems in place to the ordering, receipt, prescribing, storage, disposal and administration of medicines. The staff team demonstrated knowledge when outlining procedures and practices on medicines management. Regular medicines management audits were completed and a review of these indicated satisfactory compliance.

The provider had implemented arrangements to safeguard residents from abuse. For example, staff had received relevant training to support them in the prevention and appropriate response to abuse. Inspectors found that staff spoken with were aware of the procedures for responding to safeguarding concerns, and residents reported to inspectors that they felt happy and safe living in their home.

Staff were cognisant of each resident's personal interests and preferences for activities, and ensured these were scheduled and planned for them. However, there were inconsistencies reported in respect of the timeframe required to book staff for activities to be facilitated. This required review to ensure a consistent process which was upholding residents' rights to freedom and autonomy.

Improvements were required to the oversight of residents' care plans, to ensure that these were informed by an assessment of need from a relevant multidisciplinary professional and clearly reflected best practice in supporting residents' assessed needs. Enhancements were also required to ensure that all residents had timely access to public health screenings to ensure their best possible health, and to improve the availability of accessible information regarding the screenings to support decision making.

Regulation 10: Communication

A number of residents living in this centre required communication supports. One resident had received an assessment in respect of assistive technology and

inspectors were told that this enabled the resident to communicate with others. This resident had also developed a communication system through using eye movements. Inspectors were told that there were approximately ten staff who were skilled in understanding this system. Both inspectors saw different staff communicate effectively with the resident. However, one key staff would be retiring in the coming months and that there was an absence of planned training programme to upskill other staff.

Another resident, who communicated through non-verbal means, relied on staff members to ask yes and no questions in order for them to express their choices. However, this system potentially limited the resident's ability to freely express themselves, as they were limited by the questions which staff members asked. Inspectors were told that the staff team knew the resident well and what they liked to talk about; however, a communication system which could better uphold the resident's freedom and autonomy in communicating had not been explored with them.

This resident's communication care plan was maintained in document format and was up-to date. However, it had been drawn up without being informed by an assessment of the resident's communication needs by a relevant professional. For example, there was no communication assessment available in the resident's current or archived files, to support the recommendations made in their communication care plan.

Judgment: Not compliant

Regulation 13: General welfare and development

Residents had opportunities to engage in activities that aligned with their preferences, interests, and wishes during the day time.

An activities coordinator was integrated into the staff team with the primary responsibility of encouraging residents to participate in activities of their choice. They aimed to meet with each resident weekly to discuss and plan these activities. A review of the digital resident records confirmed that these meetings were consistently held. For instance, some residents were accompanied for ice cream outings and shopping trips in the local community, while another resident received assistance in booking and purchasing tickets for a comedy show.

Residents were supported to take part in a range of social and developmental activities both at the centre, at their perspective day services, and in the community. Suitable support was provided to residents to achieve this in accordance with their individual interests and capacities. Residents had up-to-date information and supports recorded under "My Occupation and Leisure Time" on the provider's IT system. Residents were supported to engage in activities and hobbies that were of

interest to them including trips to the zoo, visit family, gardening, yoga, bingo, arts and crafts, and going out for walks.

Residents were also supported to maintain and develop relationships. Residents were free to receive visitors, and were supported to visit their friends and family as they wished.

Further discussion in relation to arrangements for residents during the evening time is discussed under Regulation 9: Resident's Rights.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were good arrangements for the oversight of medicine practices, including regular audits and checklists, to ensure that the provider's policy was adhered to and that any discrepancies were identified.

Each resident's medicines were administered and monitored in line with best practice as individually and clinically indicated. Inspectors reviewed and observed the practices and arrangements for medication management in the centre and one inspector carried out an observation of medication administration practices being implemented for one resident. Staff were knowledgeable of the professional guidelines and professional code of practice that governed medicines management and adhered to these requirements.

The inspector observed the resident's medicines were securely stored, and clearly labelled with relevant information such as expiry dates. The inspector also reviewed the resident's prescription sheet and medicine administration records. The documents contained all necessary information, and evidenced that the resident received their medicines as prescribed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed the individual assessments and care plans of six of the residents. Improvements were required to the individual assessments and care plans, in particular to ensure that they were informed by relevant multidisciplinary professionals and were regularly reviewed and updated.

On the second day of inspection, inspectors were told that residents had been provided with access to multidisciplinary professionals based out of the service but that this service had been withdrawn a number of years ago. The provider

submitted information, the day after the inspection, which detailed that residents still had access to this service. However, there was an absence of evidence to show that residents' assessments were informed by relevant health care professionals in a number of areas areas relating to health and social care needs.

For example, in relation to assistance with toileting and elimination, inspectors were told that a resident used a portable toileting aid for elimination. There was a protocol in place to guide staff in supporting the resident. However, the protocol was not in line with best practice in relation to positioning them. The overall arrangement required further consideration and review by an appropriately qualified multidisciplinary professional who, in turn, could provide suitable direction and guidance. At the time of inspection, it was not demonstrated if consideration had been given to the potential for the portable toileting aid to impact on continence in the long-term or in exacerbating any underlying elimination difficulties which sometimes required medication to treat and manage.

Improvements were also required to ensure that care plans for skin integrity were implemented in a timely manner. Inspectors asked staff about a potential skin integrity concern for a resident presenting as redness on their foot. Inspectors were told that staff were observing the resident to try to identify the cause, but that there was no documented care plan in place to manage the issue in the interim to prevent it's progression. The person in charge, told inspectors on the second day of inspection, it had been identified as a Grade 1 pressure sore and that a care plan was required.

Some care plans were out-of-date and required review. Additionally, information in residents' care plans did not always clearly set out who had created and was responsible for the plan and it's recommendations in order to demonstrate the multidisciplinary professional involvement.

For example, one resident who presented at risk of choking, and did not adhere to feeding, eating, drinking and swallowing (FEDS) recommendations, had a choking risk management and intervention plan on their file. However, the plan was out of date, having been last reviewed in 2019. In addition, it was not clear if the plan and the guidelines and directions within it had been created, documented and signed by a multidisciplinary professional with expertise and skills in this specialised support need.

Judgment: Not compliant

Regulation 6: Health care

Improvements were required to ensure residents were supported to achieve their best possible health outcomes.

A number of residents did not have access to many of the public health care screening programmes. For example, while some residents accessed bowel

screenings and breast check programmes not all female residents were signed up for, or had been supported to access, cervical check screening programmes. Inspectors were told that some residents had declined these screenings. However, there was a lack of consistent documentation to record residents' decisions not to avail of health screening programmes. For example, where residents had made the decision to decline certain medical treatments or health screening programmes, it was not recorded that this information was brought to the attention of their medical practitioner for the purposes of keeping the most up-to-date information relating to the resident's healthcare with their physician.

In addition, care plans detailing alternative measures which could be implemented should a resident decline to avail of public health screening programmes, were not in place. For example, a resident had declined a breast check screening, as was their choice, but it was not demonstrated what alternative preventative health care planning support arrangements were put in place to manage this health care need.

Other female residents had been not received an invite for breast check screenings. The provider had not followed up with the residents' general practitioners or the screening programmes providers in relation to this.

Judgment: Not compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. For example, there was a clear policy in place with supporting procedures, which clearly directed staff on what to do in the event of a safeguarding concern. In addition, all staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns.

Staff spoken with throughout this inspection were knowledgeable about their safeguarding remit and regulatory responsibilities. For example, all safeguarding concerns had been reported to the Chief Inspector.

At the time of this inspection there were no safeguarding concerns open. Residents living in this designated centre had resided together for considerable time, and reported to inspectors that they were very happy living in the designated centre and felt safe. One inspector reviewed the records of previous safeguarding incidents identified during the previous inspection in October 2023 and found that they had been appropriately reported and managed to promote the residents' safety. Staff spoken with on the day of inspection including the person in charge reported they had no current safeguarding concerns.

Following a review of four residents' care plans it was identified that safeguarding measures were in place to ensure that staff provided personal intimate care to residents who required such assistance in line with their personal plans. Residents

experienced a service where they were protected and kept safe. They were involved in all aspects of decision-making in relation to safeguarding.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had completed works to the premises to make the centre more homely to residents which was a positive and effective action taken by the provider.

However, a review and consideration of some practices implemented in the centre was required to ensure a rights based approach to care and support was being implemented and to challenge any potentially institutional style practices operated in the centre.

Most residents had retired to their bedrooms by 6:40pm on the evening of the first day of inspection. Inspectors were told that this was as per residents' choice. However, there were no other choices of activities made available for residents and therefore, it was not clear if the residents' choice was in response to a lack of alternative options.

Inspectors were also told that residents were required to book evening activities in advance in order for these to be facilitated. There were discrepancies reported to inspectors of how far in advance activities were required to be booked, with management of the centre saying that notice was required only two days in advance and staff informing inspectors a week in advance. Improvements were required to ensure that there was a consistent protocol in place in respect to booking staff for evening activities, and to ensure that this protocol was upholding residents' rights to freedom and autonomy as best as possible.

There were some staff practices implemented for all residents that required consideration and review to ensure they were being implemented for a known assessed risk or assessed need for a specific resident and not put in place for all residents as part of staff routine.

Inspectors asked staff members on duty about how residents were provided with snacks when the chef had gone home for the evening. Inspectors were told that staff members went to residents' rooms with a trolley which had yoghurt, custard and cereal. Inspectors were told that some residents chose to have other snacks which could be provided, such as tea and toast.

While this demonstrated residents were provided with food during the evening time, the practice of using a trolley with set snack option items required consideration and review to ensure a more person-centred service provision was made available to residents which could facilitate choice, was informed by their individual prescribed

nutrition and FEDS plans and encouraged a more home-like system aligned with a rights based approach to person-centred care.

Other practices in the centre required consideration and review, for example, an informal rule was in place for all residents which, in the absence of a known safeguarding risk, had the potential to impact on residents' relationships and friendships, their dignity and privacy. Inspectors were told that male residents could not enter female residents' bedrooms, even at the invitation of the female residents, without a staff member present. The rationale for this was not established. There was no safeguarding plan in place which had identified a known risk that required this type of rule.

Inspectors asked staff members on duty about the systems and procedures in place for the night shift and were told by staff that nightly checks were completed on all residents by staff members until midnight. Nightly checks were detailed as a rights restriction practice in the provider's associated policy. This practice had not been reviewed in the context of rights restrictions, and while some resident's assessed needs may require enhanced night time checks, the balance of managing risks and promoting the rights of residents to privacy required review to ensure a rights based approach was being implemented.

Improvements were required to ensure residents were provided with information and education to assist them with understanding the purpose of screening programmes to assist residents with making an informed decisions about their health.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cara Cheshire Home OSV-0003441

Inspection ID: MON-0048091

Date of inspection: 09/09/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge with the Regional Support Team will develop a process by which the local management team will conduct a series of awareness check-ins with staff to ensure practices are in line with policy and procedures and in line with FREDA principles. Timeframe: 31/01/2026 • The Provider is conducting a review of the bi-annual audit process to enhance its effectiveness in driving improvements in the service. Timeframe: 31/3/2026 • Since date of inspection the service has successfully recruited a driver through the Community Employment Scheme. Timeframe: Completed • The Person in Charge has reviewed the service resources and has reallocated hours for driver position/s. Recruitment is ongoing. Timeframe: 31/01/2026 • The Provider and Person in Charge endeavour to ensure that all candidates for available care staff positions hold a full clean driver's license and are able to support residents in use of the service's vehicles.	
Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• Since date of inspection the Provider has engaged in the development of Plain English and Easy Read contracts of care. Each resident will be invited to a meeting with a member of the local management team to discuss their service agreement using the template most appropriate for them. If a resident needs assistance to sign a document they will be given the opportunity to choose a person to confirm their agreement in line with how they like to communicate their wishes and decisions. Timeframe: 31/12/2025

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Person in Charge will ensure all notifications of incidents will be submitted in line with the required time frames as set out in the Regulations. Timeframe: 31/12/2025

• The Regional Clinical Partner is completing a review of the local systems in place for identifying, reviewing, and reporting restrictive practices and will identify where areas of improvement are needed. Timeframe: 31/12/2025

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• The SLT has conducted assessments of communication needs, communication preferences, and historic interventions for 2 residents to date and same will be added to each person support plans. This SLT input will be conducted for any others with communication support needs. Timeframe: 28/02/2025

• The SLT has engaged with a resident and the activities coordinator to outline his preferences and needs in relation to supporting and training staff in understanding his communication requirements. This will be captured within his communication support plan to instruct all new and existing staff.
Timeframe: 30/11/2025

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The Regional Clinical Partner has conducted a review of residents Holistic Needs Assessments and any gaps in relation to skin care plans and health screening have been addressed. Timeframe: Completed

• All nursing and care staff have been provided with training in the identification and treatment of skin integrity issues in line with organizational policy. Where a skin concern is identified the regional clinical partner reviews same with the organizational clinical team on a monthly basis.

• The CNM1 has arranged for an SLT with a speciality in choking to review the plan created previously and to update if required. Timeframe: 31/12/2025

• The OT has conducted a review of the protocol in relation to one resident's practices re toileting. Where the individual has a preference that is not in line with best practice this has been assessed by the OT as safe and same incorporated in the support plan. Timeframe: Completed

• An Holistic Needs Assessment for each person is reviewed at least annually. The Person in Charge will engage with the HSE MDT team in an effort to reestablish their involvement in support plan reviews, in addition to their current practice of providing support on a referral basis. Timeframe: 30/11/2025

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• In tandem with the GP a review has been conducted of all health screening requirements and residents' health needs and support plans will be updated by the CNM1 and Regional Clinical Partner. Timeframe: 30/11/2025

• Any resident who chooses not to engage in a recommended screening will have a risk assessment for declining same and will be provided with information/education and supports for informed decision making. Timeframe: 30/11/2025

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The activities coordinator is consulting with each resident around their wishes for in service activities particularly in the evenings. Details of these meetings are recorded on the care management system. Timeframe: 30/11/2025 • Various activities such as movie night, karaoke night, book club, games, arts & crafts will be offered as possible activities that may be of interest to some residents. Over the coming months we will trial these activities to gauge interest. Timeframe: 31/01/2026 • Planned meetings re individual social events or activities planned with residents will continue as before with social events scheduled and recorded in each resident's records. This intentional approach will ensure the resident remains at the centre of the decision-making process. • Following inspection all staff in the service have been provided with the opportunity to participate in FREDA principles training. This training allows reflection of practices that are not in line with the FREDA principles. This training will be ongoing in 2026 and is expected to become a core module of Cheshire Ireland induction training. • The Person in Charge with the Regional Support Team will develop a process by which the local management team will conduct a series of awareness check-ins with staff to ensure practices are in line with policy and procedures and in line with FREDA principles. Timeframe: 31/01/2026 • Discussions are taking place with each resident to ensure that any likes, dislikes or preferences around food (particularly when the chef is not available) are identified. These will be recorded on their relevant support plan to ensure that each resident has available to them food or snacks of their choice at any time. The practice of using the trolley was discontinued on date of inspection. • The Regional Clinical Partner is completing a review of the local systems in place for identifying, reviewing, and reporting restrictive practices and will identify where areas of improvement are needed. Timeframe: 31/12/2025 • In tandem with the GP a review has been conducted of all health screening requirements and residents' health needs and support plans will be updated by the CNM1 and Regional Clinical Partner. Timeframe: 30/11/2025 • Any resident who chooses not to engage in a recommended screening will have a risk assessment for declining same and will be provided with information/education and supports for informed decision making. Timeframe: 30/11/2025	

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	28/02/2025
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	31/01/2026
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	Substantially Compliant	Yellow	31/01/2026

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/03/2026
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	31/12/2025
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the	Not Compliant	Orange	31/12/2025

	following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.			
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	31/12/2025
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/12/2025
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive	Not Compliant	Orange	31/03/2026

	assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.			
Regulation 05(1)(b)	The person in charge shall 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 subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/03/2026
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).	Not Compliant	Orange	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,	Not Compliant	Orange	31/03/2026

	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.			
Regulation 05(6)(a)	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 be multidisciplinary.	Not Compliant	Orange	31/03/2026
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.	Not Compliant	Orange	31/03/2026
Regulation 05(6)(d)	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	Not Compliant	Orange	31/03/2026

	circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	30/11/2025
Regulation 06(2)(c)	The person in charge shall ensure that the resident's right to refuse medical treatment shall be respected. Such refusal shall be documented and the matter brought to the attention of the resident's medical practitioner.	Not Compliant	Orange	30/11/2025
Regulation 06(2)(e)	The person in charge shall ensure that residents are supported to access appropriate health information both within the residential service and as available within the wider community.	Not Compliant	Orange	30/11/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature	Not Compliant	Orange	31/01/2026

	of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/01/2026