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:	Galway Cheshire House
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Galway
Type of inspection:	Announced
Date of inspection:	10 June 2025
Centre ID:	OSV-0003445
Fieldwork ID:	MON-0039110

About the designated centre

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

The centre is a purpose built premises that provides a residential service for residents with physical and sensory disabilities. Each resident has their own apartment which contains an open plan kitchen, living and bedroom area. Each apartment also has an en-suite bathroom and additional equipment such as hoists are installed to support some residents with their mobility requirements. The centre also supports residents with some medical needs but a twenty four hour nursing presence is not maintained and this is clearly stipulated in the statement of purpose and function for the centre. The provider employs a number of staff members directly; up-to-three staff members support residents during day-time hours and there are two waking staff to support residents during night-time hours. Some residents have funded personal assistant arrangements through an external agency and these assistants also contribute to the support and care provided to residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 10 June 2025	13:45hrs to 18:15hrs	Ivan Cormican	Lead
Wednesday 11 June 2025	09:30hrs to 14:30hrs	Ivan Cormican	Lead
Tuesday 10 June 2025	13:45hrs to 18:15hrs	Carmel Glynn	Support
Wednesday 11 June 2025	09:30hrs to 14:30hrs	Carmel Glynn	Support

What residents told us and what inspectors observed

This was an announced inspection conducted following the provider's application to renew the registration of this centre. As part of the inspection process, inspectors reviewed residents' questionnaires, met with eight of the nine residents, observed work practices of four staff and one personal assistant and also discussed care with one of these staff members. Inspectors reviewed four personal plans, incidents since the last inspection in March 2025 and also the centre's rota over a 12 week period. Daily notes for two residents were also reviewed with one resident's daily notes reviewed for the 30 days previous to this inspection and the other resident's daily notes examined for a 42 day period of time. The inspection was facilitated by the centre's person in charge.

As part of the announced inspection process, residents are offered questionnaires to complete in relation to their experience of living in this centre. Eight questionnaires were returned, and these were reviewed by inspectors. The questionnaires highlighted a high level of satisfaction with the service as a whole and complemented the delivery of care by Cheshire staff. Although there was a high satisfaction level among residents, this inspection highlighted deficits in the provision of care for two residents. The model of care in this centre relied on some residents having personal assistants to support them with everyday tasks such as personal care, mobility, cleaning, cooking and shopping. These personal assistants were employed by an external organisation who interacted directly with the residents in relation to the provision of these assistants. The principle of this model is residents self directing their care which promoted their rights and independence; however, inspectors found that work practices were of a poor standard and the provider had no oversight of how personal assistants operated in this centre, which placed some residents at risk. This issue will be discussed in the subsequent sections of this report.

The centre was a purpose built, single storey facility and was registered to cater for up-to-ten residents. Each resident had their own studio-style apartment which had an open plan kitchen/dining/living and bedroom area, and also a separate en-suite bathroom. Apartments were moderately sized, with each having an individual front door. The apartments could also be accessed via the main building, through a door which opened onto a main internal corridor.

Due to the design and layout of the building, the centre could support wheelchair users and residents with reduced motility. The centre's statement of purpose outlined that the centre could also support residents with physical and sensory disabilities. On the day of inspection, six residents were wheelchair users and two residents could mobilise independently. One other resident also required support and supervision when mobilising due to a significant falls risk. Seven of the residents required support with their personal care, including showering and intimate care, nutrition, toileting and everyday tasks such as preparing meals and keeping their apartments clean and tidy. One resident could require up-to-three staff for transfers

to-and-from their bed, shower or toilet and two other residents required the support of two staff for similar care needs. The remaining wheelchair users required support from one staff member in regards to their activities of everyday living and overall the inspectors found that a high level of support and care was required in this centre.

The model of care employed by the provider included personal assistants which were assigned to seven of the nine residents. The number of hours assigned to each resident varied, but 91 personal assistant hours were offered from Monday to Friday. Some residents used two hours each day, one had a personal assistant Mondays and Fridays, while another had a personal assistant three days per week. The model of care in principle was that residents directed their assistants in relation to what aspects of care they needed support with; however, inspectors found that everyday practice was of a poor standard. An inspector met with a resident in their apartment while they were supported by a personal assistant and found that their apartment was untidy and not cleaned to a good standard. This resident also required support with their personal, nutrition and dental care and the inspector reviewed their notes. Over a sixteen day period there were two recorded showers and the resident was offered a shower on just one other day during this period of time. The resident also informed the inspector that they had concerns in regards to their dental care; however, over a six week period, dental care had been provided once. The resident also explained that they had a "sweet tooth" and they loved soft drinks, chocolate and snacks. A dietition had seen them in the past and made recommendations but there were no records maintained in regards to the provision of their nutritional needs to determine if they were at a minimum, offered a healthy or nutritious diet.

Of concern is that this resident had the provision of a personal assistant every Monday; however, on the second day of inspection the person in charge learned that this assistant had been on leave for the last four weeks and they had not been replaced. There was no indication that this information had been relayed to the staff team to assume responsibility in relation to provision of groceries which the personal assistant normally managed. This resident also preferred to stay up late at night and they often did not retire to bed until the early morning. In one example, the inspector saw that the resident did not retire to bed until the night staff were due to go off duty. The resident's personal assistant signed the visitors book as having attended the centre at 10:30, but they did not sign as to what time they left the centre. In addition, the inspector found the timing of this personal assistant's support for this resident of little benefit to them as staff and the person in charge indicated that more than likely they would be asleep at this hour of the morning and preferred to get up in the afternoon.

The inspector reviewed daily notes for one other resident, and also spoke for a period of time with them after their personal assistant had left. Again, their apartment had not been tidied and it was cluttered. The inspector reviewed their daily notes for the 30 days prior to this inspection and found that the provision of care by Cheshire staff was of a good standard. Attention to detail was in place in regards to the provision of personal care, wound management and support with some meals. However, even though the resident received personal assistant

supports from Monday to Friday, only one entry was made by their personal assistant in the 30 days prior to this inspection. The resident told the inspector that the assistant did their grocery shopping and helped them with dinners, some of which were shop bought convenient meals; however, there were no dietary records in place to indicate that the resident was supported to have nutritious meals. Again, this was of concern, considering the resident had an active wound; the provider should have ensured that their nutritional intake was maintained to a good standard at all times.

The inspector also met with two other residents who availed of personal assistants. One resident said that they were happy with their personal assistants who were very nice and again the second resident also stated that their assistants were very pleasant. The second resident said that they had been supported by their assistants for over a year and although they complete all requested tasks, the resident had to remind them each day what to do. The resident also stated that they have to be reminded to sign for any cleaning duties they completed, and at over a year later these reminders are something which they shouldn't have to do each day they were supported.

Since the last inspection of this centre, there had been marked improvements in the provision of care for one resident who was at a high risk of falls. Additional measures had been implemented including reviews and the installation of a sensor to alert staff when this resident was possible mobilising. As soon as the alert was triggered staff went to their apartment to see if they required assistance. The inspector spoke with this resident who stated that they were very happy with the provision of care from Cheshire staff and they understood the need for the monitoring device. It was clear from reviewing daily notes and talking to staff, that this monitor was triggered multiple times each day, with staff attending each time. The inspector found that this had been a significant change in work practices since the last inspection and although it was a positive example in regards to the provision of care, it did place additional pressures on the staff team to offer comprehensive care to the other residents. This could be seen in the provision of poor quality care to some residents who used personal assistants, with Cheshire staff unable to consistently fulfill the shortfall in their care.

Although there were issues in relation to the provision of basic care for some residents, other residents who met with inspectors were very happy with the service they received. One resident spoke at length with inspectors and they also showed the inspectors their apartment. They stated that staff were very nice and that they could go to the person in charge if they had any issues. They liked their independence and they headed off on the public bus each day, either into Galway city or to surrounding areas like Limerick or Athlone. They were also looking forward to an upcoming trip to Lourdes which was organised by a local religious group. They were supported by the centre's social facilitator to book this trip, which they said was a great help to them. Another resident also chatted for a period of time and again they stated that they were very happy in the centre. They said that staff were very nice and always there if they needed assistance. However, one resident was unhappy with the level of support they received in relation to community access. They spoke with an inspector and clearly stated that they were very happy with staff

and the level of care and support which was offered in the centre. They told the inspector that in the past they were generally satisfied with how often they got out and about in their local community. As the conversation progressed the resident stated that they were no longer happy with the level of social supports they received. They told the inspector that staff member was assisting them with sourcing a personal assistant but this remained an unresolved issue on the day of inspection.

In summary, some residents reported high levels of satisfaction with the service they received and it was clear that the care and support offered by Cheshire staff was person centred and held to a good standard. However, the overall model of care adopted by the provider in relation to the use of personal assistants, in many regards was not fit for purpose and resulted in some residents receiving a poor quality service.

Capacity and capability

This inspection highlighted fundamental issues in relation to the model of care and the provision of services for some residents. Inspectors found there was little or no oversight of the care offered by resident's personal assistants which placed some residents at risk. The delivery of care for these residents was of an overall poor standard and fundamental change was required to improve the quality of care which they received.

The inspection was facilitated by the centre's person in charge who had a good knowledge of the service and also of the residents' care needs. They had implemented actions since the last inspection to bring about positive change in regards to a resident's risk of falls and they had a good understanding of current issues in the centre. The person in charge spoke at length with inspectors in regards to the provision of care and it was clear that they promoted the well being and welfare of residents. They described how they had met with the external organisation who oversaw the provision of personal assistants and highlighted the need for them to complete daily notes of the care which they had completed. Personal assistants were also familiarised with the centre's electronic notes system; however, they consistently failed to complete records in relation to the provision of care. There was also no information in place in relation to which elements of care they were responsible for, and as seen in this inspection this lead to significant deficits in areas such as personal care, dental care and nutritional supports.

Inspectors found that this model of care in this centre was significantly challenged. The role of the person in charge is to ensure the effective governance and operation of the centre; however, the use of personal assistants and their lack of accountability undermined the ability of the person in charge to fulfill the duties of their role. In addition, the role of the provider is to ensure that the centre is safe and effectively monitored but the provider's oversight arrangements failed to

recognise the risks associated with this model of care and the use of personal assistants in this centre.

There had been some positive changes in relation to staffing since the last inspection of this centre. The support at night had increased to two waking night staff and residents reported that this was a welcome change. However, improvements were required in relation to the overall day time arrangements. Some residents reported that they were satisfied with the number of staff on duty while two residents reported that there wasn't enough staff on duty and that they often had to wait on the provision of care, while another resident only received four hours for social and community access each week. Furthermore, inspectors found that the staffing arrangements at the weekends also required review. The allocation of 91 personal assistant hours was in place from Monday to Friday; however, this was reduced to 15 hours at the weekend. Although there was less supports required in terms of attending appointments at the weekend, inspectors found that the weekend staffing arrangements also required review to account for the reduction in care hours delivered.

Overall, inspectors found that the model and provision of care in this centre required extensive review to ensure that residents' basic care needs were met and held to a good standard at all times.

Regulation 15: Staffing

While improvements had been made with some elements of staffing in the centre, inspectors found that the model of care, which included the allocation of personal assistants, lead to an inconsistent approach to the delivery of care and placed residents at risk. Deficits were found in relation to the provision of personal care, nutrition and dental care and the arrangements which were in place failed to ensure that the person in charge had oversight of all work practices in this centre.

In addition, the provision of staffing numbers at the weekend required review to take into account the reduction in personal assistant hours and the provider failed to ensure that sufficient staff numbers were in place to support one resident in relation to community access.

The inspectors also reviewed four staff files. While they contained most of the information and documents as required under Schedule 2 of the regulations, photo identification was missing from two of the files, and a copy of qualifications was missing from one of the staff files.

Judgment: Not compliant

Regulation 16: Training and staff development

The provision of training was based on the assessed needs of residents. Staff in this centre required training in areas such as epilepsy management, and the safe management of people with dysphagia. Mandatory training was also required in the areas of safeguarding and behavioural support.

However, there was one staff who had yet to complete safeguarding training, four staff who had yet to complete positive behavioural support training and two staff who required refresher training in this area of care. In addition one staff member had not completed safe management of people with dysphagia training while another was due refresher training. The area of first aid had not been completed by all staff and three staff also required refresher training.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre had a clear management structure in place with the assigned person in charge maintaining overall responsibility for the day to day oversight of care. The person in charge had a range of internal audits which ensured that areas of care such as medications, healthcare and personal planning was held to a good standard.

Although the provider had completed all reviews and audits as set out in the regulations, these reviews failed to account for the deficits in care which were found on this inspection. Inspectors found that the provider did not have oversight of the care offered by residents' personal assistants which placed them at risk. Deficits were found in relation to the provision of personal and intimate care, dental care and also in relation to nutritional support.

Inspectors also found that the lack of accountability of residents' personal assistants also undermined the role and function of the centre's person in charge. The person in charge had recognised the need for residents' personal assistants to record care which they offered on a daily basis; however, records were not consistently completed by all assistants despite the efforts of the person in charge in relation to the provision of training and engaging directly with their employer. The provider failed to recognise and therefore act to resolve this issue which was having a significant impact on the provision of care and also prevented the person in charge from fulfilling all duties of their role.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspectors found that there were appropriate processes in place regarding admissions to the centre.

The provider was in the process of admitting a new resident to the centre. The person in charge reported that the prospective resident had visited the centre twice in recent months in preparation for moving to the centre, and their admission was imminent, with recruitment ongoing for two additional posts required for additional staffing in the centre. The new admission had been discussed at the last resident's meeting, so residents were aware of the new admission to the centre. The person in charge reported that the prospective resident had a specific neurological disorder, and that training on this disorder would be planned for staff.

One of the inspectors reviewed details of planning around the new admission, with an assessment of needs completed, and risk and care needs identified, and an admissions meeting held to discuss the person's needs.

The provider had contracts of care in place for residents who lived in the centre. An inspector reviewed one of the resident's tenancy and service agreements. It outlined the rent they would be charged, the services to be provided to the resident and the provider's responsibilities. The agreement was signed by the resident and the service manager.

Judgment: Compliant

Regulation 4: Written policies and procedures

The Schedule 5 policies were reviewed by an inspector. They were available for staff in the centre, and all of the policies required under Schedule 5 of the regulations were in place. However, 11 out of the 20 policies in place had not been reviewed within three years as required by the regulations. For eight of the 11 policies that required review, the date for review was in 2025, with three requiring review since 2024. The person in charge reported that policies were currently under review by the national management team who held responsibility for reviewing policies.

Judgment: Substantially compliant

Regulation 21: Records

The provider failed to ensure that adequate records were maintained in this centre in relation to the provision of food.

Judgment: Substantially compliant

Quality and safety

Inspectors found that significant improvements were required in relation to risk management, the provision of food and nutrition and also community access for one resident. The main issue in relation to risk management and nutritional supports was due to the lack of oversight in regards to the provision of care by residents' personal assistants. In addition, although the majority of residents had good access to their local community, one resident was dissatisfied in relation to their level of support and access which had the potential to impact upon their rights. In terms of this report, this issue will be discussed under the regulation for welfare and development.

The person in charge had a good understanding of risks which had the potential to impact upon individual residents. The actions from the centre's last inspection had been successfully implemented with a significant decrease in falls for one resident which improved the safety of care which they received. The person in charge had also identified a recent trend in medication errors with additional actions taken to address this trend. Some staff had repeated medication administration training and staff were assigned to complete the administration of medications each day. The person in charge was keeping these actions under review and the issue had also been raised with the provider.

Although the day to day management of safety issues in the centre were maintained to a good standard, the provider had failed to recognise the overall risk associated with the lack of oversight of residents' personal assistants in relation to the provision of care. As discussed throughout this report, residents' personal assistants failed to complete basic care for some residents which placed them at risk and resulted in them receiving a poor quality service. For example, the provider failed to demonstrate that some residents' personal, intimate and dental care needs were consistently met. Concerns were also raised in relation to the provision of food and nutritional supports for these residents. Again, the provider was unable to demonstrate that these residents received a healthy and nutritious diet or a home cooked meal in a consistent manner.

Residents who used this service had a diverse range of needs. Two of the nine residents did not have mobility issues and they could access their local community and the surrounding areas independently. The remaining residents were wheelchair users with two residents also having a visual impairment. Five of these residents required additional supports to access their local and the majority of residents voiced their satisfaction with the service they received. However, inspectors found that one resident had limited opportunity to engage in community based activities at a time of their choosing. The resident explained to an inspector that they only received four hours support each week for community access and they had not been outside of the centre in the week previous to this inspection. Inspectors found that

significant improvements were required in relation for opportunities for this resident to access their local community in a consistent manner.

In summary, many of the residents who lived in this centre had good access to their local community, were happy and received a good quality service. However, inspectors found that a lack of oversight of the care delivered by residents' personal assistants was having a negative impact on the quality and safety of care in this centre. In addition, improvements were also required in regards to community access for one resident who reported little opportunity to engage in activities which they enjoyed.

Regulation 10: Communication

For residents who required communication supports, there was a comprehensive support plan in place which outlined their communication needs. There was a section called 'Communicating my wishes and decisions' which outlined how to support the resident in making a decision and their communication preferences. For example, for one resident it was outlined that they like to communicate using email and that they like to have face to face meetings.

One of the residents uses an assistive technology device to aid their communication, and their support plan outlined the supports they require regarding its use.

Resident's meetings were held monthly between residents and staff. Updates in relation to staffing, new admissions, facilities and various other topics were shared with residents. Residents also had the opportunity to raise any items they wanted to discuss.

The resident had their own television in their apartment, and they could also access newspapers and magazines if they so wished.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were well supported with their personal possessions. Each resident had their own apartment in which they stored their personal possessions. There was ample storage in each apartment and residents who met with inspectors stated that their personal items were respected by staff.

Some residents required some supports with their finances and the person in charge had recently met with two residents to discuss safeguarding. The person in charge

had identified that additional oversight supports may be required and they were at the initial stages of exploring how best to support resident's independence while ensuring they were safeguarded financially.

Judgment: Compliant

Regulation 13: General welfare and development

Residents who used this service had varying needs and while some could access their local community independently, others required support due to the nature of their disability.

Most residents stated that they had no issues in terms of getting out and about; however, one resident was not satisfied with their supports in terms of community access. They had made the provider aware of their concerns who was advocating for personal assistant hours for them. However, on the day of inspection, the resident remained unhappy with the opportunities for social engagement which they received.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Several of the residents that inspectors spoke with reported that they were supported either by Cheshire staff or by their personal assistants with their shopping and food preparation.

Inspectors found that the provider failed to demonstrate that all residents were provided with a varied and nutritious diet at all times. Records in relation to the provision of nutrition were of a poor standard and this presented as a risk for a resident who reported a poor dietary intake.

In addition, ensuring that residents with active wounds have a good nutritional base is an integral element of care; however, there were poor nutritional records maintained for a resident with an active wound which had the potential to impact on their recovery.

Judgment: Not compliant

Regulation 26: Risk management procedures

The person in charge maintained responsibility for the management of incidents and day to day risks in this centre. Risk assessments were in place for issues in relation to falls, safeguarding, money management and tissue viability with comprehensive controls and reviews in place.

Although specific risks in relation to residents were well managed, the provider failed to recognise the overall risk that the lack of accountability of residents' personal assistants presented to the provision of care.

The inconsistent approach to care and lack of oversight on behalf of the provider had lead to poor outcomes for two residents and resulted in them receiving a poor service.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire precautions were taken seriously by the provider and fire safety systems such as emergency lighting, fire alarm system and fire fighting equipment was in place and had an up to date service schedule. Staff had completed fire safety training and a staff member who met with the inspector had a good understanding of resident's individual and collective evacuation requirements.

Although fire safety was promoted, some improvements were required. For example, the centre used a phased horizontal evacuation; however, the most recent fire drills for one phase of the evacuation were not prompt in nature and required further review. In addition, two fire doors were not functioning properly and the provider had not completed a recent fire drill to reflect minimum allocation of staffing in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had comprehensive personal plans in place which contained guidance for staff on how to support them. They covered various aspects of their care and support needs, such as lifestyle supports, communication, daily living supports, personal and intimate care, health and wellbeing and medication management.

Inspectors reviewed two of the resident’s personal plans. They had a Holistic Needs Assessment which outlined the areas the person is independent with or requires support. This informed their Identified Needs, which outlined the type of support required.

It was evident that the information was reviewed regularly and informed by any changes in care needs. For example, for one resident who had been experiencing an increase in falls, their support plan was updated outlining that they had agreed to wear a call bell pendant during the day, so that they could call for assistance if needed.

The provider also had a system to support residents in identifying and achieving personal goals. Outcomes were identified for each resident, with actions taken in relation to each outcome recorded on the online system. Residents were supported by Social Supports Facilitators, who worked with residents on planning and achieving these goals. An outcome for one resident was that they would like to attend historical lectures monthly, and the actions recorded outlined the steps taken in relation to this goal being supported for this resident.

The Social Supports Facilitator spoken with spoke about working on outcomes with residents, including a current group music project on song writing, which will be recorded in the coming months.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors observed that residents were treated with dignity and respect over the course of the two day inspection. Residents reported that staff were very nice and that they always knocked prior to entering their apartments. Residents also reported that their personal correspondence and communications were respected and information in relation to the promotion of rights was clearly displayed.

Residents also attended monthly meetings to discuss the operation and running of their home and overall residents who met inspectors felt that their rights were promoted.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Galway Cheshire House OSV-0003445

Inspection ID: MON-0039110

Date of inspection: 11/06/2025

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A review will be carried out with residents who currently have a PA service to determine their wishes for the provision of personal , social and household supports, including which provider they wish to provide their support and days and times when they wish supports to be provided • Following the review, the centre's weekly staffing roster will be altered to meet the needs of individuals as agreed in the review. Where Cheshire are required to supplement hours previously provided by the external service, this will be confirmed with the funder to transfer hours from the external provider. • Photo ID x 2 and qualifications x 1 have been requested and will be inserted into staff files where relevant. • One resident has been offered additional social support hours, and these will be implemented at agreed times with the resident on a weekly basis.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • 1 x staff member who was yet to complete a Safeguarding module has left the organization. All staff are up to date with safeguarding training. • Positive behavioral Support Training was completed by 9 staff on 30th June 2025, and all staff are up to date • 3 x staff attended First Aid training on 13th June 2025, and all staff are up to date • 1 x staff completed Dysphagia training on 2nd July 2025.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• • The Provider has commenced recruitment for a Full-Time Service Co-Ordinator to strengthen the Governance in the center.
• The Provider will audit the effectiveness of the external PA service for Residents on a six-monthly basis or more frequently if the need arises.
• Where issues have arisen for an individual in the six-monthly audit, they will be resolved through the Joint Service Agreement.
• A review will be carried out with each resident into their wishes for the provision of social and household support, including which provider they wish to provide their support and days and times when they wish support to be provided.
• Where a resident requests a change in provider this will be implemented by the removal of the existing service and replacement by a social support service from Cheshire Ireland
• Where a resident requests that their External Provider remains in place to support them in some areas the following actions will take place:
a) A Joint Service Agreement between the Individual, Cheshire Ireland and the External Provider will be put in place for each service containing:
• Schedule of hours to be delivered.
• Support tasks to be delivered by each provider
• Appropriate means of recording of support delivered
• Escalation pathways for complaints, safeguarding concerns, and feedback.
• Six-monthly service reviews between the Individual, Cheshire Ireland & The External Provider.
• Clarity of responsibilities of both Providers to the individuals.
• Clarity on notifications of absence to individual and Cheshire Ireland so alternative arrangements can be provided.

The PIC and External Provider Co-Ordinator will hold a recorded Quartterly review of the operation and effectiveness of each service or more frequently if issues arise.

The Regional Manager of Cheshire Ireland and Area Manager of the external Provider will hold a six-monthly Review of the operation of any joint services based on findings of the six-monthly Audit.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The schedule 5 Policy Folder is now available to all staff on the Cheshire Ireland Intranet & has been updated to include all review dates.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A meeting was held on 01/07/2025 between the Provider and the External Provider of PA support at which the following was agreed:

• A review will be carried out with each resident into their wishes for the provision of personal, social and household support, including which provider they wish to provide their support and days and times when they wish support to be provided.
• Where a resident requests that their External PA service remains in place to support them in specific areas, an individual Joint Service Agreement will be put in place.

This will include the following:
1. Appropriate recording of support delivered by both Cheshire and any external PA.
2. External Provider PA will be instructed by the External Provider to ensure recording of any support offered by a PA into Cheshire's daily communication notes.
3. The recording of support offered by all staff will be monitored by the PIC and local management team in Galway Cheshire House.
4. Where corrective action is required, this will be escalated by the PIC to the external Provider's coordinator for follow-up.

The PIC and External Provider coordinator will hold a recorded Monthly review of the operation of each service.
The Regional Manager of Cheshire Ireland and Area Manager of the external Provider will hold a Bi-Annual Review of the operation of any joint services.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

One resident had been considering making an application for a social support service from an external Provider but has now declined the offer of external PA service.

The Provider is reviewing this resident's wishes for social supports with them and will implement increased social supports for them if they wish. This offer will be revisited at each of the individual's service review meetings to allow for them to reconsider the decision at any time.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The PIC will ensure that an eating and drinking support plan is in place for each resident should they require one.
• A meal plan has been implemented for a resident who requires extra nutritional support due to skin integrity issues.
• The CNM has met with another resident to discuss and implement a meal plan. The residents support for meals has been documented in their care plan and shared with external provider as per the persons wishes.
• Meal plans will be reviewed for all residents and where support is required from external providers, these plans will be shared with all Cheshire and External Service PAs.
• Where external provider PAs are involved in meal preparation they will be required to complete daily notes of food offered and prepared for each resident based on the person's agreed support plan.
• The Community Dietician has regular input for all residents who require support.
• 1 resident who has increased dietary requirements due to deterioration in skin integrity, had appointment postponed by Community dietician, appointment was due to take place on 18th June. The dietician has been contacted by CNM and requested to provide a new date.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A risk assessment associated with the provision of external PA service has been reviewed and updated to reflect the following controls:

• A review will be carried out with each resident into their wishes for the provision of

personal, social and household support, including which provider they wish to provide their support, days and times when they wish support to be provided.
• Where a resident requests a change in provider this will be implemented by the removal of the existing service and replacement by a social support service from Cheshire Ireland.
• Where a resident requests that their External Provider remains in place to support them in some areas the following actions will take place:

b) A Joint Service Agreement between the Individual, Cheshire Ireland and the External Provider will be put in place for each service containing:

• Schedule of hours to be delivered.
• Support tasks to be delivered by each provider
• Appropriate means of recording of supports delivered
• Escalation pathways for complaints, safeguarding concerns, and feedback.
• Bi-annual service reviews between the Individual, Cheshire Ireland & The External Provider.
• Clarity of responsibilities of both Providers to the individuals.
• Clarity on notifications of absence to individual and Cheshire Ireland so alternative arrangements can be provided.

The PIC and External Provider Co-Ordinator will hold a recorded Monthly review of the operation of each service.

The Regional Manager of Cheshire Ireland and Area Manager of the external Provider will hold a Bi-Annual Review of the operation of any joint services.

Individual Joint Service Agreements for any resident who wishes to remain in receipt of a PA service scheduling daily support to be completed
Each Joint Service Agreement will contain an escalation pathway in the event of a resident not receiving the stated support.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
We take fire safety seriously and are acting to meet all requirements:
1. Fire Drills
• We reviewed the recent fire drills and evacuation times.
• All Fire drills will be conducted in line with Cheshire Ireland's Fire Safety Policy.
2. Minimum Staffing Drill
• A fire drill with the lowest number of staff present will be carried out on 8th July 2025. This is currently 2 staff members.
• The results will be used to improve our fire plan if needed.

3. Fire Doors
• We are currently coordinating with the contractor to arrange a site visit and carry out the necessary works without delay. The contractor will confirm the relevant timeframe for completion. The timeframe will depend on the extent of works required.
• All fire doors will be checked by the contractor to make sure they are working properly.
4. Ongoing Checks
• Monthly fire safety checks will now take place, led by the Person in Charge.
• This includes drills, fire doors, and staff understanding.
Staff have been updated on these actions. We are fully committed to maintaining a safe environment for residents and staff.

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 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	31/07/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/08/2025
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all	Not Compliant	Orange	15/07/2025

	staff the information and documents specified in Schedule 2.			
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	08/07/2025
Regulation 18(2)(b)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Not Compliant	Orange	31/07/2025
Regulation 18(2)(c)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	Not Compliant	Orange	31/07/2025
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary	Not Compliant	Orange	31/07/2025

	needs and preferences.			
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/09/2025
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.	Not Compliant	Orange	30/09/2025
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.	Not Compliant	Orange	30/09/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a	Not Compliant	Orange	30/09/2025

	system for responding to emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/08/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	11/07/2025
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	11/07/2025
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where	Substantially Compliant	Yellow	11/07/2025

	necessary, review and update them in accordance with best practice.			