Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Waterford Cheshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003457</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Waterford</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>The Cheshire Foundation in Ireland</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Patrick Quinn</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Julie Pryce</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Maureen Burns Rees</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>12</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>4</td>
</tr>
</tbody>
</table>
About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**
From: 26 May 2016 09:30  
To: 26 May 2016 17:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Residents Rights, Dignity and Consultation</td>
</tr>
<tr>
<td>04</td>
<td>Admissions and Contract for the Provision of Services</td>
</tr>
<tr>
<td>05</td>
<td>Social Care Needs</td>
</tr>
<tr>
<td>07</td>
<td>Health and Safety and Risk Management</td>
</tr>
<tr>
<td>08</td>
<td>Safeguarding and Safety</td>
</tr>
<tr>
<td>11</td>
<td>Healthcare Needs</td>
</tr>
<tr>
<td>14</td>
<td>Governance and Management</td>
</tr>
<tr>
<td>16</td>
<td>Use of Resources</td>
</tr>
<tr>
<td>17</td>
<td>Workforce</td>
</tr>
</tbody>
</table>

**Summary of findings from this inspection**
This was a follow up inspection carried out to monitor compliance with the regulations and standards and to follow up on two pieces of information submitted to HIQA in relation to allegations that residents’ rights were severely restricted.

The previous inspection was on 24 November 2015 and as part of the current inspection, inspectors reviewed the actions the provider had undertaken since the previous inspection.

How we gathered our evidence
As part of the inspection, the inspectors met with a number of residents. Residents told the inspectors that they were happy in their homes, and with the support they received, with the exception of the removal of their rights to make their own decisions about medications.

The inspector also met with the person in charge and staff members. The inspector observed practices and reviewed documentation such as personal plans, risk assessments, money management plans, policies and staff files. Interviews were carried out with the person in charge, the person participating in management and staff members.
Description of the service
The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. Inspectors found that the service was being provided as it was described in that document. The facility had the capacity to accommodate 16 residents in total. Each resident had an accessible self contained apartment. A number of apartments were located on the first floor and were accessible by lift. Other apartments were accessed from outside the main building with their own private front doors. The centre was seen to be purpose built and provided accommodation of high quality which was very clean and well maintained.

Overall findings
The provider had not put adequate arrangements in place to uphold the rights of residents. Residents’ autonomy in medication management had been restricted without consultation and contrary to the ability and wishes of residents.

Otherwise inspectors found that residents had a good quality of life in the centre and that they were happy in their homes. The inspectors found that residents’ healthcare needs were being met and that they had opportunities to participate in activities of interest to them.

However there was still a significant level of non-compliance with the regulations which resulted in some negative outcomes for residents.

Good practice was identified in areas such as:
• provision of healthcare (Outcome 11)
• residents were supported to have a meaningful day (Outcome 5)
• adequate resources were available to meet the needs of residents (Outcome 16)

The inspectors found that the lack of effective governance and management systems had resulted in:
• residents’ rights not being promoted by staff (Outcome 1)
• charges to residents not being identified clearly (Outcome 4)
• training not being provided to staff in relating to fire safety (Outcome 7)
• inadequate assessments in relation to restrictive practices (Outcome 8)
• Lack of performance management of staff (Outcome 17)

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013, 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.

### Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

#### Theme:
Individualised Supports and Care

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

### Findings:
Inspectors found that a significant rights restriction identified in the previous inspection had not been addressed.

On the previous inspection it had been found that residents were not being supported to make decisions about their own medication where the only support they required was physical support. This issue had still not been resolved. The person in charge outlined his efforts to resolve the issue, but the inspectors found that there had been no improvement in the negative outcomes for residents.

Residents who had physical disabilities, but not intellectual disabilities, and who did not require any assistance with decision making, were not being supported to make their own decisions about medication administration. For example, because they required the assistance from staff to physically take the medication, residents were denied the right to make a decision to take a pain killer for a headache, or to begin a course of antibiotics immediately after they were prescribed.

Residents told the inspectors that they felt discriminated against because of their physical disabilities. It was clear that issue was causing frustration and upset to residents, who felt their autonomy was being denied and that the current practice was a serious restriction of their rights. They told the inspectors that their previous autonomy in decision making in relation to medication had been removed suddenly and without consultation, and that this issue had caused strain in their relationship with staff.
Judgment:
Non Compliant - Major

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors were concerned that service agreements still did not include all the required information, and that residents were required to pay for necessary adaptations to their environment in the absence of any written agreement.

One of the residents required modifications to their bathroom in order to manage their physical needs. These modifications had been paid for by the resident, and an email from the housing manager outlined the requirement for the resident to also pay to have the bathroom returned to the original state if they ever left the service.

These charges were not outlined in either the service agreement with the resident, or in the tenancy agreement. The admissions policy stated that the environment must meet the needs of residents prior to admission, and the person in charge was in the process of sourcing funding for adaptations to another resident who was awaiting admission.

In addition, the service agreements did not include the provision for a resident becoming acutely ill, although this had been an agreed action at the previous inspection. A new template for the service agreement had been developed, but had not yet been put into practice, although the agreed timeframe following the previous inspection had been 31 March 2016.

Judgment:
Non Compliant - Moderate
Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspectors found that systems were in place to support residents to have a meaningful day, and that all residents had a personal plan in place.

Personal plans had been found to be comprehensive and detailed on the previous inspection, and inspectors found on a review of a sample of personal plans on this occasion that this standard had been maintained. Plans contained detailed information on each resident, and goals had been reviewed regularly. The care plans in relation to healthcare needs were in sufficient detail as to guide staff.

The inspectors were satisfied that residents continued to have opportunities for social participation, education and training, and had a meaningful day in accordance with their needs and preferences.

The person in charge assured the inspectors that he had put in place systems to ensure that any discharges of residents from the service would be conducted in a safe and planned manner, as agreed following the precious inspection. An admissions and discharges policy was in place in sufficient detail as to guide practice, dated January 2016.

Judgment:
Compliant

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

Theme:
Effective Services
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There were some systems in place in relation to fire safety, but improvements were required in fire safety training and in the risk management processes.

Fire drills were conducted regularly, on at least a quarterly basis, and a check list was maintained to record the outcome of the drill and areas for improvement. There was annual servicing of fire equipment, and quarterly maintenance of alarms and emergency lighting. Fire doors were in place to each individual apartment and between each compartment of the main building. A fire safety policy was in place and a fire audit was conducted every two years, the last being in March 2015.

However not all staff had received fire training, and this was the third consecutive inspection where fire training was required.

There were some individual risk assessments in place, for example in relation to swallowing difficulties, the use of lap belts and manual handling. However, there were no centre specific environmental risk assessments in place, and the risk register included only risks relating to the centre as a workplace for staff.

There were appropriate hygiene and infection control systems in place. Cleaning equipment was stored safely and a colour coded flat mop system was in place. Cleaning rotas were maintained and staff reported that each apartment was deep cleaned on a weekly basis. Staff described appropriate infection control procedures, and were observed to maintain appropriate hand hygiene.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
Improvements had been made since the last inspection in relation to staff training in the management of challenging behaviour, but improvements were still required in the management of restrictive practices.

It had been identified at the previous inspection that where there were restrictive practices in place there was no evidence of the consideration of alternatives, and no thorough assessment in place. This had not been addressed within the agreed timeframe of 30 January 2016, the date given by the provider in response to the previous inspection report.

For example, where bed rails were used there was no thorough assessment, no evidence of multi-disciplinary consultation, and no evidence of consideration being given to alternatives so as to ensure that the restriction was the least restrictive available to manage the risk.

A consent form was in place, which asked for detail of alternatives, but this section had been completed with 'the use of pillows or foam bolsters' neither of which is an alternative to the restriction.

However, a register of restraints was kept, in accordance with the requirements of the regulations.

An issue identified on the previous inspection in relation to a particular resident being charged for services which were provided without charge to others had been resolved, and the charges were no longer incurred.

The inspectors found that not all staff had received training in the protection of vulnerable adults. This has been ongoing issue at the last three inspections and had not been addressed. Those staff who had received training were knowledgeable about the types and signs of abuse, and the procedures to follow if there were any allegations of abuse. There was a policy in place relating to the protection of vulnerable adults.

Systems relating to the management of residents’ money were not sufficiently robust to safeguard residents. There was a policy on supporting people in the management of money and property, which required an Individual Money Management Plan for each resident to include detail of the level of support they required. In a sample of three such plans reviewed by the inspectors one was complete, one only partially complete and one was blank. The plan that was complete was incorrect in that it stated that the resident did not require any support, however it was evident that staff did support the resident in some purchases.

The policy also required that safeguarding systems be put in place including records of all financial transactions. However records examined by the inspectors showed that this was not always the case.

The person in charge had ensured that staff were in receipt of training in relation to challenging behaviour, as agreed following the previous inspection, although there were currently no residents who engaged in challenging behaviour. There was a current policy
in place to provide guidance in the provision of behaviour support.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Healthcare had been found to be delivered in a safe and appropriate manner on the previous inspection, and inspectors found that this good practice had been maintained.

Each resident had an annual health assessment, and other assessments were also in place, for example pressure area assessments and BMI records. Residents had access to allied healthcare professionals in accordance with their needs, including general practitioners, speech and language therapy and pharmacy.

Healthcare plans were in place for all issues reviewed by the inspectors, including swallow care plans and bowel healthcare. The implementation of these plans was recorded.

**Judgment:**
Compliant

### Outcome 14: Governance and Management
*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was a new person in charge who had been in post for just under two months at the time of the inspection. The person in charge was interviewed by the inspectors and engaged in the inspection process. He was found to be appropriately skilled, experienced and qualified, and outlined plans to rectify many of the areas for improvement identified by inspectors during the course of the inspection.

A system of fortnightly audits has been introduced in the centre, and the first of these had been conducted. An unannounced visit had been conducted by the person in charge, in which an audit had been conducted which was based on the regulations. However, very few actions had been identified in this audit, and none of the issues found by the inspectors had been identified. This audit was not focussed on the quality and safety of care.

A medication audit had been conducted in December 2015, and the identified actions in this audit had been addressed. However, whilst this was intended to be a quarterly audit, no further audit had been conducted.

The person in charge presented a record of an unannounced visit which had been conducted on behalf of the provider in November 2015. However, several of the actions reviewed by the inspectors had not been implemented. For example, a review of call bell times was required but had not been done, and gaps in staff training which had been identified had not been addressed. There was still no annual review of the safety and quality of care and support as required by the regulations.

A system of meetings was in place including regional team meetings and centre staff meetings. In addition the person in charge prepared a fortnightly monitoring report for senior management which included issues such as incidents, medication errors and staffing issues.

There was no system of performance management in place as required by the regulations. Any discussions that were held with staff in relation to supervision made no mention of performance, and there was no structure in which to address performance issues.

Judgment:
Non Compliant - Major
### Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

**Theme:**
Use of Resources

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors had been concerned during the last inspection that there was only one vehicle available to residents, and that this was insufficient to meet their transport needs. This had been addressed and there were now two vehicles available to residents, one of which could accommodate three wheelchair users.

**Judgment:**
Compliant

---

### Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

**Theme:**
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors found that while improvements had been made in the staffing levels and skill mix since the last inspection, further improvements were required. The staff rota was not based on the needs of the residents. Improvements were required in the supervision and performance management of staff and in the maintenance of information in staff files.

The person in charge had conducted an assessment of the dependency levels of residents, and there had been an increase in the number of staff on duty each day since the previous inspection. In addition a nurse had been recruited so that there would be nursing cover every day of the week, and the documentation in relation to this recruitment was presented to the inspectors. However it was clear that the staff rota
and shift pattern was not planned in accordance with the needs of residents. There was a rigid rolling roster in place, and the number of staff did not change according to how many residents were present, for example if several residents came into the centre for respite breaks.

Some improvements had been made in the maintenance of staff files since the previous inspection, and a database of the information included had been introduced. However the information required by the regulations was still not present for each staff member. References were missing for some staff, and documentary evidence of qualifications was missing for others.

Training had been provided for staff in medication management, first aid, food hygiene and the management of dysphagia. However, as discussed under Outcome 7 not all staff had received fire safety training, or training in the protection of vulnerable adults.

**Judgment:**
Non Compliant - Moderate

---

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

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

Centre name: Waterford Cheshire
Centre ID: OSV-0003457
Date of Inspection: 26 May 2016
Date of response: 7 July 2016

Requirements

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

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that residents were supported to make decisions about their care.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

**Please state the actions you have taken or are planning to take:**
This issue was discussed at a joint working group between Cheshire Ireland and Trade Unions, service users received regular updates regarding the medication self-management issue. The policy and documentation regarding this issue was reviewed. A medication waiver, giving any service user in Cheshire who has the capacity, to self-manage their medication with staff administering their medication was put in place. This waiver works within Cheshire Ireland’s current medication policy. This has been agreed since 23/08/2016 with a view to have it in place by the 30/09/2016

**Proposed Timescale:** 30/09/2016

---

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all aspects of service provision and charges were included in written contracts of care.

2. **Action Required:**
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

**Please state the actions you have taken or are planning to take:**
A new service agreement and tenancy agreement is now in place – Service Manager will be meeting with all service users during the month of September to update them on the changes as we are now in line with the Residential Tenancy Board. This will be complete by the 30th of September 2016. The service agreement sets out and clearly defines the service users and landlords roles and responsibilities.

**Proposed Timescale:** 30/09/2016
### Outcome 07: Health and Safety and Risk Management

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were not adequate systems in place for the assessment and management of risk.

**3. Action Required:**
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
The local risk register is to be updated to include all local - environmental, general and clinical risks. This register will also list all the independent service users risk assessments.

**Proposed Timescale:** 31/07/2016

### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Alternatives to restrictive practices had not been considered, and adequate assessments had not been conducted.

**4. Action Required:**
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

**Please state the actions you have taken or are planning to take:**
Fire Training has been booked for all staff who require training in fire safety.

**Proposed Timescale:** 31/08/2016
5. **Action Required:**
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**
Restraint assessment form has been updated to include an area, that will record what information was offered to the service user and also for an external professional i.e. occupational therapist / physiotherapist to sign that they were present at the meeting. Meetings are being scheduled with the service users who use bedrails These meetings will demonstrated informed decision making for service users who decide that they would like to use bedrails or alternatives to bedrails.

**Proposed Timescale:** 31/08/2016
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all staff had received training in relation to the protection of vulnerable adults.

6. **Action Required:**
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**
All outstanding training for adult protection excluding 1 staff member who was on a/l has occurred on the 30th of June 2016. Staff member to be trained when they return from a/l. New Recruits and staff who require refresher training will be scheduled on an ongoing basis. Train the Trainer in Safeguarding has been completed nationally with identified staff to ensure that local services have access to training for staff on an as needs basis

**Proposed Timescale:** 31/07/2016
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Systems to protect residents personal moneys were not robust.

7. **Action Required:**
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.
Please state the actions you have taken or are planning to take:
All Service users will be reviewed under the money management policy. All service users to have an individual risk assessment regarding the safeguarding of their finances.

A robust individualised money management plan will be developed for service users who Cheshire has access to their monies. The plan will also include receipt retention and recording of all transactions.

Proposed Timescale: 30/09/2016

Outcome 14: Governance and Management
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems of audit did not effectively monitor the service.

8. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
Unannounced Cheshire inspection occurred on the 14th & 15th of June by 3 inspectors. All Action plans are being collated into 1 action plan. Actions are being addressed based on priority and date. Quarterly Medication audits occurring and they are being actioned CNM1 and also Service Manager, following each quarterly report.

Proposed Timescale: 31/08/2016
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care and support.

9. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
An Annual Review Group has been set up by the Cheshire Senior Management Team to develop a document based on the recent HIQA Guidance on completing an annual
review in services. This group will report to the Senior Management Team within 2 months for sign off on the new document. In the mean-time we will begin a process of engaging with service users and their families to ascertain their views on the service for inclusion in the review when it is completed.

**Proposed Timescale:** 31/12/2016  
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was no system in place for the management of staff performance and development in accordance with the requirements of the Regulations.

10. **Action Required:**  
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:  
This issue is currently in discussions at the joint National Forums. Upon agreement the performance management tool will be utilised. In the meantime 1:1 meetings will be held with staff to ensure they have the opportunity to discuss training needs, issues arising in their day to day work and general feedback.

**Proposed Timescale:** 30/09/2016

**Outcome 17: Workforce**  
**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The staff rota was not based on the needs of residents.

11. **Action Required:**  
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:  
A Needs Analysis and also a social care need analysis is currently in process and will be completed by the end of July. The Roster will then be reviewed and steps will be taken to manage the roster depending on the outcome of these analysis.

**Proposed Timescale:** 30/09/2016
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all of the information required under Schedule 2 was in the staff files.

**12. Action Required:**
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

**Please state the actions you have taken or are planning to take:**
Staff file information is being updated into a database. All staff have been requested to supply the outstanding documentation.

**Proposed Timescale:** 31/08/2016