



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Wolseley Lodge
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Carlow
Type of inspection:	Unannounced
Date of inspection:	08 December 2021
Centre ID:	OSV-0005342
Fieldwork ID:	MON-0034821

About the designated centre

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

Wolseley Lodge is a detached two storey dwelling located on the outskirts of a town for four people, male or female, over the age of 18 years. This dwelling consists of eight bedrooms. The bedrooms which are occupied by residents are ensuite. The remaining bedrooms are used for office space for staff and one is used as a storage room. There is a open plan kitchen/dining/lounge area which has double doors linking the patio area and garden. The centre provides a service to people with physical disabilities including wheelchair users, and is staffed both day and night. The service is operated as a nurse led model with the additional support of care staff and ancillary supports such as maintenance, gardening and transport as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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
Wednesday 8 December 2021	10:00 am to 3:10 pm	Leslie Alcock	Lead

What residents told us and what inspectors observed

The purpose of this inspection was to follow up on a number of areas that were found to be not compliant with regulations and standards on the previous inspection which took place on 23rd September 2021, in order to inform the designated centre's application to renew their registration.

The inspection took place during the COVID-19 pandemic and therefore appropriate infection control measures were taken by the inspectors and staff to ensure adherence to COVID-19 guidance for residential care facilities. This included the wearing of personal protective equipment (PPE) and maintaining a two metre distance at all times during the inspection day.

This centre was a large country dwelling located on the outskirts of a small town. The centre provided a home to three residents both male and female. The inspector had the opportunity to meet with all three residents as part of this inspection. In addition, members of management and staff were spoken with as part of this inspection.

On arrival to the centre on this unannounced inspection, inspectors observed that all the residents were still in their bedrooms. One resident was still sleeping and the other two residents were being supported by staff with their morning routine. While a staff member showed the inspector around the centre, the inspector observed staff preparing for a Christmas lunch for the residents which is part of the provider's Christmas wellbeing week. The Christmas wellbeing week also included activities such as bingo, afternoon tea, a community walk, a Christmas jumper day and a random act of kindness challenge.

The centre was a large and homely bungalow. Each resident had their own bedroom which included an en-suite bathroom, and there was a communal open plan kitchen, living and dining room. Each bedroom was decorated in accordance with the residents' personal needs and interests.

On the day of the inspection, the inspector met with the resident's, observed where they lived, observed care practices, spoke with staff and reviewed the resident's documentation. In general, the inspector found that residents appeared in good health and appeared familiar and comfortable with the staff and the environment in which they lived. On the day of the inspection, the residents and staff took part in a quiz where the person in charge was the quiz-master. The inspector observed staff encouraging the residents to take part in the quiz and promoted some healthy competition and fun among all involved.

Staff spoken with on duty demonstrated familiarity with the residents and their assessed needs. The inspector observed warm, respectful and meaningful interactions between staff and residents.

In summary, based on what was observed, communicated and reviewed, it was evident that the residents appeared to have received good quality care and support. The next two sections of this report outline the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. Some improvements were required to ensure that the service provided was safe at all times and to promote higher levels of compliance with the regulations. The inspectors found that further improvement was required in areas such as fire safety and notifications of incidents.

Capacity and capability

Overall, the inspector found that the registered provider demonstrated the capacity and capability to support the residents in the designated centre. There were management systems in place to effectively monitor the quality and safety of the care and support delivered to the residents. On the day of inspection, there were sufficient numbers of staff to support the residents assessed needs.

There was a defined governance structure in place within the centre with clear lines of accountability identified. The person in charge was found to be competent, with appropriate qualifications and experience to manage the designated centre. This individual demonstrated good knowledge of the residents and their support needs. The person in charge was also supported by a deputy manager who had a regular presence in the centre and a regional manager who also demonstrated oversight. There was also evidence of regular management meetings taking place.

There was an appropriate number and skill mix of staff to meet the residents assessed needs and the provider ensured continuity of care with an established staff team and a small group of regular relief staff. The statement of purpose had been updated to reflect the staffing arrangements specific to this designated centre. The staff completed training in line with the residents needs. The training that was outstanding at the last inspection was complete with the exception of managing behaviour that challenge. The provider had scheduled dates in place for this training which were in line with their compliance plan following the last inspection.

The actions from the last inspection in relation to the notifications of incidents, were for the most part completed. However, upon review of the adverse events, a minor injury sustained by a resident was not notified to the office of chief inspector in the centre's most recent quarterly report as required.

Registration Regulation 5: Application for registration or renewal of registration

The provider did not submit all of the required information with the application to

renew the registration of this designated centre. While efforts have been made to secure a lease for the centre to cover the new registration cycle, this remained outstanding.

Judgment: Not compliant

Regulation 15: Staffing

There was an appropriate number and skill mix of staff present on duty in this centre. There was a planned and actual rota in place that reflected the staff on duty on the day of the inspection. The staff rota also clearly stated the role and job title for each member of staff. The outreach service hours provided by staff to a member of the community was clearly outlined on the rota and it was evident that it was separate to the staffing provision in the centre. It was also evident that community outreach provision which is funded separately did not impact the staffing provision to the residents in the designated centre.

There were no staff vacancies and the centre had a small number of regular relief staff working in this centre to ensure continuity of care. Agency staff were not used in this centre and the inspector found a consistent level and standard of staffing was evident in the centre. Staff spoken with were found to be caring, professional and knowledgeable about the residents in their care.

Judgment: Compliant

Regulation 16: Training and staff development

The staff were supported and facilitated to access appropriate training including clinical training that was in line with the residents' needs. The inspector viewed evidence of training records that related to the gaps identified in the last inspection in September. The training that was outstanding was complete with the exception of managing behaviour that challenge. The provider had scheduled dates in place which were in line with their compliance plan following the last inspection.

Judgment: Compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure. There were clear lines of accountability and responsibilities and effective arrangements in place to ensure the

safe and quality delivery of care to the residents. The registered provider had appointed a full time, suitably qualified and experienced person in charge. This individual had responsibility for another designated centre within the service and divided their time appropriately across both centres. The person in charge demonstrated good oversight of the centre and had a regular presence.

While there were plans in place for a centre specific six monthly audit and the annual review, they were not completed on the day of inspection as they were not scheduled for completion until January as per the provider's compliance plan from the last inspection. The inspector saw evidence such as questionnaires for residents that the provider was planning to distribute in preparation for the annual review. There was an audit system in place that demonstrated the provider was for example trending and analysing adverse events in order to learn from and improve the quality and safety of the service provided.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose and function is a governance document that outlines the service to be provided in the designated centre. The statement of purpose contained all the information as required by the regulation. Since the last inspection, the statement of purpose was updated to reflect the staffing arrangements specific to this designated centre. The statement of purpose also provided further information on the staffing arrangements in relation to the outreach service to a member of the community provided by staff in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The actions from the compliance plan following the last inspection were for the most part completed. For instance; omitted notifications identified on the last inspection were retrospectively submitted, records of adverse events were reviewed weekly and the Cheshire National Safeguarding Lead was scheduled to meet designated officers, coordinators and nurses to provide clarity and support in relation to reporting and notifying safeguarding concerns. However, upon review of the adverse events, a minor injury sustained by a resident was not notified as required.

Judgment: Not compliant

Quality and safety

The inspector reviewed a number of key areas to determine if the care and support provided was safe and effective to the residents at all times. This included meeting residents and staff, observing care and support and conducting a review of records, risk documentation and fire safety documentation. Overall, the inspector found that the centre provided a comfortable home and person centred care to the residents. The management systems in place ensured the service provided appropriate care and support to the residents. For the post part, the actions identified on the last inspection were addressed or an appropriate plan was in place, however, further improvement was required in relation to fire safety.

The designated centre was decorated in a homely manner. The residents bedrooms were decorated in line with their preferences and pictures of the residents were located throughout the centre. Following consultation with the residents and their family, the provider had a plan in place to develop a new visiting area where residents could host visitors in an area other than their bedrooms.

It was evidenced that the management team had regular oversight of the service provided and appropriate risk management procedures were in place. A number of incident reports were reviewed by the inspector and it was found that these were appropriately documented and responded to, with evidence of oversight from the person in charge and the deputy manager. Inspectors found that there were systems in place to assess and mitigate risks. There was a centre specific risk register in place and individualised risk assessments. Risks relating to the current COVID-19 pandemic had also been carefully considered, with appropriate control measures in place.

A number of areas were identified on the last inspection in relation to fire safety. While fire drills had been completed since the last inspection, the provider had not completed a full evacuation with the lowest number of staff as outlined in their compliance plan on the day of the inspection. Evidence of a full evacuation drill with the lowest number of staff was submitted the day after the inspection. Following the last inspection, the provider commissioned an external fire competent expert to conduct an assessment of the fire doors. This assessment identified a number of areas that required attention. While the assessment was complete in line with the compliance plan, there was no plan in place or schedule for when the required work identified would commence or be completed.

Regulation 11: Visits

It was identified at the last inspection that there was no suitable private area for the residents to facilitate visitors other than in the residents bedrooms. The inspector found evidence that the provider had taken steps to engage with the residents and

their families to establish the best way to accommodate visits. Following consultation with the residents and their families, the provider identified an area in the hallway that could facilitate visits. The inspector reviewed records of the consultation process and spoke with a resident about this who advised they and their family were happy with this arrangement. The provider had plans to complete the work on the new visiting area by the end of the year, which was in line with their compliance plan from the last inspection.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had detailed risk assessments and management plans in place which promoted the safety of residents and were subject to regular review. There was an up to date risk register specific to this designated centre and individualised risk assessments in place which were also updated regularly. There was an effective system in place for recording adverse incidents. This system also included a post incident analysis that recorded the type of incident, immediate actions taken and if further action was required. The adverse events register was reviewed weekly and discussed at local management meetings where further action to a particular incident if required was decided and planned. All the adverse events were compiled into monthly reports which were audited by local managed and trended locally and nationally within the organisation in order to learn from, avoid recurrence and improve the overall quality and safety of the service provided.

Judgment: Compliant

Regulation 28: Fire precautions

A number of areas were identified on the last inspection in relation to fire safety. For instance; gaps around a number of fire doors were observed rendering them ineffective, the person emergency evacuation plans (PEEPS) required review to ensure different evacuation routes were considered, evacuation plans were not on display and fire drills with the lowest number of staff to simulate night time conditions had not been completed. Upon review, the personal emergency evacuation plans had been updated to reflect different potential evacuation routes and different modes required to support residents to evacuate safely. In addition to this, an evacuation plan was on display in each residents bedrooms and in appropriate areas throughout the centre. While a number of fire drills had been completed since the last inspection, the provider had not completed a full evacuation with the lowest number of staff as outlined in their compliance plan on the day of the inspection. Evidence of a full evacuation drill with the lowest number of staff was submitted the day after the inspection. Following the last inspection, the

provider commissioned an external fire competent expert to conduct an assessment of the fire doors. This assessment identified a number of areas that required attention. While the assessment was complete in line with the compliance plan, there was no plan in place or schedule for when the required work identified would commence or be completed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

While immediate action was taken on the day of the last inspection in relation to appropriate storage of thickening powder, the inspector also observed the appropriate storage of the medication on the day of the inspection. Staff also demonstrated knowledge in relation to the possible risks associated with this medication if not stored safely.

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	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant

Compliance Plan for Wolseley Lodge OSV-0005342

Inspection ID: MON-0034821

Date of inspection: 08/12/2021

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
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
<p>Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration:</p> <p>A letter of Comfort was sent to HIQA on 14/01/2022 outlining the commitment of Respond to extending the Lease on Wolseley to Cheshire on the expiration of the current Lease.</p> <p>This will be followed by the full signed Lease agreement between Respond and Cheshire Ireland by 22nd Feb 2002.</p>	
Regulation 31: Notification of incidents	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 31: Notification of incidents:</p> <p>The National Safeguarding Lead has met with the Designated Officers and other staff and clarified issues around the reporting and notification of Safeguarding concerns</p> <p>All notification reports will be reviewed prior to submission to HIQA to ensure that all minor injuries are captured in the reports. These notifications will be cross referenced with the internal AER tracker to ensure all notifications including the quarterly reports are fully completed.</p>	
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The works arising from the fire door inspections will be completed by Feb25th 2022

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	22/02/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	25/02/2022
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	Substantially Compliant	Yellow	09/12/2021

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 31(1)(c)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.	Not Compliant	Yellow	09/12/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Yellow	22/12/2021
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following	Not Compliant	Orange	31/01/2022

	incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).			
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