Isle of Man Government
Reiltys Ellan Vannin

Department of Health and Social Care
Rheynn Slaynt as Kiarail y Theay

Regulation of Care Act 2013

Adult Care Homes

Cushag House

Unannounced Inspection

Completed on 10/5/17

08.35 – 13.40

Registration and Inspection Unit 3rd Floor,
Murray House, Mount Havelock
Douglas, Isle of Man, IM1 2SF

Contents

Completing and returning your report

To complete your report form, enter text by clicking on the box see the instructions below.

Use the tab key to move to the next box.

1. Provider's action plan
    a. Add details of your actions to complete the requirements/recommendations (if applicable)

2. Provider's comments/response.
    a. Confirm you have read and agree/disagree the contents of the report by clicking on the appropriate box
    b. State any factual inaccuracies found, add comments (if applicable)
    c. Sign (type name when returning electronically) and date.

3. Return your report to **randi@gov.im** within 4 weeks.

4. Do not use any other method e.g. links to Cloud or other file sharing services

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Part 1: Service information

Part 2: Descriptors of performance against Standards

Part 3: Inspection Information

Part 4: Inspection Outcomes and Evidence and Requirements

When making decisions the Registration and Inspection Unit have regard as to how well the service meets the Adult Care Homes Standards (April 2017). Providers of services are required, as part of their conditions of registration, to fully comply with the minimum standards.

This report identifies strengths and areas of good practice as well as areas where, in order to meet the minimum standards, improvement is required. It also summarises the findings of an inspection of the service and any requirements and recommendations made. It will form the basis for decisions by the Registration and Inspection Unit regarding registration, any variation of registration conditions and any enforcement action.

Standard 1 - Introduction Assessment and Admission
Standard 4 - Environmental and Personal Safety
Standard 6 - Staffing

In addition the following areas will be considered in each inspection:

Standard 7.3 - Policies and Procedures
Standard 7.8 - Quality Assurance Systems
Standard 7.9 - Annual Reports

Part 5: Provider's comment/response

Part 1 Service Information

Name of Service **Tel No: (01624)** 656070
Cushag House

Care Service Number
Not applicable

Registration number ROCA/P/
Not applicable

Address
Castletown Road
Port St Mary
IM9 5LS

Conditions of Registration
Cushag House is a Department of Health and Social Care establishment and therefore not subject under current Isle of Man law to the registration process, however this government resource is subject to statutory inspection as an adult care home under Regulation of Care Act 2013, Regulation of Care (Care Services) Regulations and Isle of Man Minimum Standards 2013.
Cushag House provides support and accommodation for up to seven adults who have learning disabilities.

Registered company name
IOM Government

Email Address
nicola.ogden@gov.im

Name of Responsible Person
IOM Government

Name of Registered Manager
Nicola Ogden – Acting Senior Residential Support Worker (ASRSW) – not registered

Manager Registration number ROCA/M/
Not applicable

Date of latest registration certificate
Not applicable

Certificate of latest manager certificate
Not applicable

Date of any additional regulatory action in the last inspection year (i.e. improvement measures or additional monitoring).
9/9/16 – meeting with ASRSW and Service Manager for Cushag House re continued outstanding requirements.

Date of previous inspection
3/8/16

Number of individuals using the service at the time of the inspection
Seven (7)

Person in charge at the time of the inspection
Nicola Ogden - ASRSW

Name of Inspector(s)
Kevin West

Part 2 - Descriptors of Performance against Standards

Inspection reports will describe how a service has performed in each of the standards inspected. Compliance statements by inspectors will follow the framework as set out below.

Compliant
Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken. In most situations this will result in an area of good practice being identified and comment being made.

Recommendations based on best practice, relevant research or recognised sources may be made by the inspector. They promote current good practice and when adopted by the registered person will serve to enhance quality and service delivery.

Substantially compliant
Arrangements for compliance were demonstrated during the inspection yet some criteria were not yet in place. In most situations this will result in a requirement being made.

Partially compliant
Compliance could not be demonstrated by the date of the inspection. Appropriate systems for regular monitoring, review and revision were not yet in place. However, the service could demonstrate acknowledgement of this and a convincing plan for full compliance. In most situations this will result in requirements being made.

Non-compliant
Compliance could not be demonstrated by the date of the inspection. This will result in a requirement being made.

Not assessed
Assessment could not be carried out during the inspection due to certain factors not being available.

Part 3 Inspection information

The purpose of this inspection is to check:

- Is the care safe?
- Is the care effective?
- Is the care compassionate?
- Is the service well led?

No	Standard	Requirements/recommendations from previous inspection	Met/not met
1.	**Standard 2.1**	The following should be remedied : • Chipped paint on some handrails in the corridors • chipped paint on a column in the dining room. • Stain on a resident's ceiling from a previous water leak. • Continence bedding dried on handrails **Timescale: November 2016**	**Met** **Not met** **Met** **Met**
2.	**Standard 2.7**	The home should ensure that all call bell cords are within reach of people. **Timescale: Immediate**	**Met**
3.	**Standard 2.10**	Getting up and going to bed times should be recorded in a support plan. **Timescale: October 2016**	**Met**
4.	**Standard 2.11 & 3.2**	All care / support plans should be reviewed at least every six months. **Timescale: November 2014** **Not Met** **Carried over 8 May 2015** **Timescale: August 2015** **Not Met** **Carried over 3 August 2016** **Timescale: Immediate**	**Met**
5.	**Standard 2.15**	Support plans should be written for residents who carry out light domestic tasks such as tidying their room. **Timescale: October 2016**	**Met**
6.	**Standard 4.5 & 7.3**	The home should have a policy and procedure specific to physical intervention and restraint. **Timescale: November 2016**	**Not met**
7.	**Standard 7.4**	Policy and procedures should be regularly reviewed. **Timescale: January 2017**	**Not met**
8.	**Standard 7.8**	The home's annual report should be written in more detail in the following sections: • Compliments • Accidents and incidents • Feedback / comments about the service • Observations of those using the	**Met**

		service **Timescale: January 2017**	
9.	**Standard 6.11 & 7.9**	Staff should have an annual appraisal / PDR of their performance. **Timescale: January 2017**	**Met**
10.	**Standard 7.10 & 3.15**	Paperwork, records and documents should be kept up to date, including: • Risk assessments • Health Action Plans **Timescale: Immediate**	**Met**
11.	**Standard 7.13**	Twice yearly written reports should be produced following a quality assessment in relation to the premises, staffing levels and skills, resident satisfaction and record making **Timescale: January 2017**	**Part met**
12.	**Standard 4.4**	The staff induction package should include a section on safeguarding to evidence that prior to attending safeguarding training, and within one week of the start date, the registered person reviews and explains the safeguarding process to a new employee. **Timescale: September 2015** **Not Met** **Carried over 3 August 2016** **Timescale: Immediate**	**Met**
13.	**Standard 4.1**	Refresher training should be sought on Adult Protection via e-learning. **Not Met** **Carried over 14 July 2014** **Timescale: November 2014** **Not Met** **Carried over 8 May 2015** **Timescale: Immediate** **Not met** **Carried over 3 August 2016** **Timescale: Immediate**	**Met**
14.	**Standard 6.7**	All staff should receive mandatory training, including: • Communication • Food hygiene • Value based training **Timescale: November 2016**	**Not met** **Met** **Not met**
15.	**Standard 3.2**	Community living assessments should be reviewed at least every six months. **Timescale: November 2014** **Not Met** **Carried over 8 May 2015** **Timescale: Immediate** **Not Met** **Carried over 3 August 2016** **Timescale: Immediate**	**Met**

16.	**Standard 3.8**	Personal goals and aims should detail the support required to meet those aims and timeframes should be set and measured. **Timescale: November 2014** **Not Met** **Carried over 8 May 2015** **Timescale: August 2015** **Not Met** **Carried over 3 August 2016** **Timescale: Immediate**	**Met**
17.	**Standard 3.9**	Residents' special moments and events section in their communication booklet should be completed. **Timescale: November 2014** **Not Met** **Carried over 8 May 2015** **Timescale: August 2015** **Not Met** **Carried over 3 August 2016** **Timescale: Immediate**	**Met**
18.	**Standard 3.12**	Leisure interests and hobbies should be identified and how these should be maintained /encouraged recorded in the residents' support plan. **Timescale: November 2014** **Part Met** **Carried over 8 May 2015** **Timescale: August 2015** **Not Met** **Carried over 3 August 2016** **Timescale: Immediate**	**Met**
19.	**Standard 3.12**	Further information on community links and contact with friends and relatives should be recorded in the support plan. **Timescale: November 2014** **Not Met** **Carried over 8 May 2015** **Timescale: August 2015** **Not Met** **Carried over 3 August 2016** **Timescale: Immediate**	**Met**
20.	**Standard 3.15**	Risk assessments should be carried out on behaviours that challenge. **Timescale: November 2014** **Not Met** **Carried over 8 May 2015** **Timescale: Immediate** **Not Met** **Carried over 3 August 2016** **Timescale: Immediate**	**Met**
21.	**Standard 1.2**	• A pre-admission assessment should be carried out on the person being	**Met**

		accommodated prior to admission taking place. • A compatibility assessment should also be completed. **Timescale: August 2015** **Not Met** **Carried over 3 August 2016** **Timescale: Immediate**	
22.	**Standard 1.5**	During the admission process, the person being admitted and / or their representative are provided with a written contract that includes details of: • Terms and conditions of residency; including fees for services not included in the contract. • Details of notice served, support provided and timeframes. • Details of services / items provided (such as newspapers, hairdressing, chiropody etc.) and if there is an additional charge. • Insurance information for personal belongings. **Timescale: September 2015** **Not Met** **Carried over 3 August 2016** **Timescale: November 2016**	**Met**
1.	**Recommendation**	Feedback is sought from family members / visitors on a regular basis.	**Met**

Feedback from relevant parties
The residents looked well in terms of their appearance and were seen to move freely around the home. The inspector was unable to receive direct feedback from the residents but observed positive staff resident interactions on the inspection. Two members of staff were spoken to on the inspection and questionnaires were left for staff, not on duty to complete and five were returned. Questionnaires were left for visiting family members to complete and two were returned.

Part 4 Inspection Outcomes and Evidence and Requirements

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 1 - Introduction, Admission and Assessment

OUTCOME: People are confident that the home's information reflects the services practice and that written information is accurate and current. The registered provider is able to clearly establish that the home's facilities and staff can meet the individual's specific needs and requirements. The admission process is planned and people are clear on the terms and conditions surrounding their residency.

Our decision:
Compliant

Reasons for our decision
The home had a statement of purpose that detailed the ethos and services available in Cushag House. It included the information set out in Schedule 3 of the Registration Regulations.

The home had not had an admission since the previous inspection. The ASRSW outlined the process if a person was identified as moving into the home. This would involve the completion of a skills, needs and risk assessment with an individual. This document covered:

- Legal status
- Staying healthy / physical health
- Emotional and mental wellbeing
- Social opportunity / education / employment
- Social activities, relationships and wellbeing
- Communication
- Domestic tasks / routines
- Finance
- Eating and drinking
- Making decisions
- Keeping safe

A Service User Impact Assessment document would be completed to identify a person's compatibility with the other people living in the home.

Written contracts which outlined the terms and conditions of residency had recently been introduced by the service and each resident now had a contract in place.

Requirements and recommendations
None

Provider's action plan
Not applicable

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 4 - Environmental and Personal Safety and Comfort

Outcome:
Systems, checks, policies, procedures and staff training ensure that people's dignity, well-being and safety is promoted and protected.

Our decision:
Substantially compliant

Reasons for our decision
Environmental risk assessments had been completed and were reviewed in April 2017.

Both a whistleblowing policy and the current Isle of Man Adult Safeguarding procedures were available in the policy and procedure file. Staff member signing sheets were kept with each policy and staff had been instructed to sign to evidence that they had read and understood them.

No safeguarding issues had been raised in the home.

The Adult Learning Disabilities Staff Induction Package format documented that within one week of the start date; the safeguarding process should be explained to the new employee.

Staff feedback confirmed that the majority had not seen any staff practice which had caused them any concern. One member of staff said that they had and had reported it. Both family member feedback questionnaires also confirmed that they had not seen any untoward staff practice.

The inspector was informed that physical intervention was not used in the home. Where required, individual Personal Intervention Plans (PIPS) to document and address behaviours were completed for a resident.

The home did not have a policy and procedure specific to physical intervention.

Staff attended MAPA (Management of Actual and Potential Aggression) training.

Individual's restriction around freedom of movement and personal liberty was discussed with the ASRSW. Resident "stranger danger" support plans recorded that the person was "not to be left alone and unsupported at any time outside the home". In the keeping safe – potential needs and risks identified section of a resident's skills, needs and risk assessment document it stated "staff to control ****** and others access to and exiting from the building". Other restrictions were recorded such as individuals not allowed access to the kitchen due to health and safety concerns.

An easy read getting things right: a comment, complaint, compliment leaflet was available by the front door of the home. This outlined the complaints stages and timescales as well as the contact details of the Registration and inspection Unit.

A comment / compliment / complaint book was examined. No complaints had been made or recorded since the last inspection. Several compliments had been made.

A fire file was examined. This contained a fire risk assessment for the home which had been reviewed in April 2017. A fire procedure specific for Cushag House had also been completed. A quarterly fire inspection checklist had been completed as well as an annual fire safety audit.

Staff had received refresher training on fire safety.

On the day of the inspection, all means of escape were seen to be free from hazards.

Records confirmed that the following fire checks were being carried out:

- weekly alarm tests
- monthly fire blankets and fire extinguisher checks
- monthly emergency lighting checks
- twice yearly fire drills – 3/9/16 & 2/3/17

The fire extinguishers had a yearly check by a fire safety engineer on 19/7/16.

Each resident had a Personal Emergency Evacuation Plan (PEEP) in relation to fire. This is an escape plan for individuals who may not be able to reach a place of safety unaided or within a satisfactory period of time in the event of an emergency.
Easy read fire evacuation posters as well as fire action notices were displayed in the home.

A health and safety file in the office was examined. This contained a corporate health and safety policy and a Health and Safety at Work Act 1974 statement in relation to Cushag House. This statement detailed staff members responsibilities in relation to:

- Moving and handling
- Control of Substances Hazardous to Health (COSHH)
- Environmental risk assessments
- Visual electrical checks
- First aid equipment and personal protective equipment (PPE)
- Fire safety checks
- Kitchen hygiene checks

The health and safety file also contained guidance on diarrhea and vomiting and guidance on infection control in nurseries, schools, workplaces and day centres.

Staff had received training on infection control.

Gloves and aprons were available for staff to use and posters on hand washing were displayed in the toilet / bathrooms as reminders. Reminders were also displayed instructing staff on the correct disposal of continence pads. The service had an infection prevention and control policy and an infection prevention and control self-audit had been completed by the ASRSW in April 2017. The audit results showed that the home was low risk in all areas.

A cleaning schedule that broke down tasks into daily / weekly / monthly / 6 monthly / annual tasks was in place for staff to follow.

Fridge and freezer temperature checks were being completed. It is recommended that the home use the Safer Food Better Business food safety management pack, including the kitchen opening and closing checks.

Control of Substances Hazardous to Health (COSHH) safety data sheets and risk assessment sheets were kept on the cleaning products used in the home. A corporate COSHH policy was also available.

The service had a health and safety at work inspectorate guidance for RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reporting requirements. A RIDDOR reporting book was kept in the health and safety file as well as a corporate incident reporting policy flowchart which guided the reader on RIDDOR reporting.

An electrical installation condition report on the building had been completed on 2/3/15.

Water monitoring to control the risk of exposure to legionella micro-organisms had taken place twice in 2016. The blenders / thermostatic mixer valves had also been checked twice in 2016. A specialist bath had a built in temperature gauge which was set so as not to go above 37 degrees centigrade.
Staff were carrying out and recording weekly temperature checks on the water throughout the building.

An oil boiler service had taken place on 13/4/16 and this should take place on a 6 or 12 monthly basis. A boiler inspection took place subsequent to the inspection on 24/5/17.

The home had in place public liability insurance which was displayed and due to expire on 31/3/18.

Requirements
Standard 4.5
The home should have a policy and procedure specific to physical intervention and restraint.
Not met
Carried over 10 May 2017
Timescale: September 2017

Recommendations
That the home use the Safer Food Better Business food safety management pack, including the kitchen opening and closing checks.

Provider's action plan
4.5 This policy is in the process of being written through the Quality and Performance Improvement Manager.

Opening and closing checks are now in place.

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 6 - Staffing

Outcome: Staff are recruited following a rigorous and robust recruitment programme. There are sufficient numbers of trained competent staff (including ancillary staff) to meet the needs of the people at the home. There are robust policies in place to ensure effective supervision and continuous professional development

Our decision:

Partially compliant

Reasons for our decision
The service had an equal opportunities employment policy.

Staff files were unable to be examined on this inspection. These files were held with the services Human Resources Department so the inspector was unable to verify if all pre-employment checks had been carried out.

The inspector was informed that all new staff spent, as a minimum, one week, shadowing experienced workers.

A new employee's probationary period consisted of a minimum of six months. Any new starter in the home would complete an Adult Learning Disabilities Staff Induction Package

Staff supervision records were examined. These evidenced that staff members were receiving 1:1 supervisions with the ASRSW four times a year. A group supervision had also taken place recently. Records of supervisions were kept and a copy given to the individual staff member.

Mandatory training on induction included:

- Moving and handling
- Food hygiene
- Medication
- Communication
- First aid
- Values into Practice (ViP)

The frequency of refresher training had been identified. Not all of the staff team had received training on communication awareness and ViP training.

Professional development formed part of the staff supervision format. This gave the opportunity for training needs to be identified and discussed.

Five staff had received an annual Performance Development Review (PDR) with the ASRSW due to complete four others.

If required, specialist training was provided for staff, including epilepsy awareness and specific medication training. One member of staff had not received this specific training and this should be arranged as soon as possible.

The majority of the staff team either held an NVQ level 2 qualification or were in the process of completing a QCF level 2 award.

Training programs were delivered by qualified trainers. The majority of the training was carried out in a face to face classroom situation with some training provided via online eLearning.

The ASRSW said that following any training attended by staff; this would then be discussed in an individual's 1:1 supervision. Staff would also be observed on shift by the ASRSW to verify if training was being practiced.

Four team meetings had taken place between April 2016 and March 2017 with one meeting taking place in May 2017.

Staffing levels to meet the needs of the residents had been identified as being three staff per shift. A staffing risk assessment had been completed by the ASRSW in April 2017. The assessment stated that one driver was required to be on each shift as well as one person who was trained in Midazolam medication administration.

Staffing rotas were reflective of the actual persons and hours worked. A Designated Person On Duty (DPOD) who was the responsible person on shift was identified on the rota. A list of the DPOD's responsibilities was listed at the front of the staff rota file.

Staff feedback confirmed that the majority believed that there was enough staff on duty, but the inspector was informed that getting shifts covered due to sickness etc could be very difficult to do

at times. The feedback from a family member questionnaire recorded that they believed that there was "not always" enough staff on duty.

Requirements

Standard 6.3

Staff files should be available for the inspector to verify that all pre-employment checks have been carried out.

Timescale: Immediate

Standard 6.9

Staff should receive mandatory training on:

- Values into Practice
- Communication awareness

Not met

Carried over May 2017

Timescale: August 2017

Standard 6.15

Staff should receive training on Midazolam administration.

Timescale: August 2017

Provider's action plan

6.3 Staff files were and are available to the inspector, but information relating to employment (DBS, references contracts etc.) were not available. They are a recent inspection requirement and this information has been requested by SRSW of OHR.

6.9 DHSC core and ALDS mandatory training policies are currently being reviewed and will cover these areas.
In the interim the Staff Induction Package is being reviewed to include further communication and values information and discussion.

6.15 Outstanding training for one member of staff has been organised.

ANY OTHER AREAS EXAMINED

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 7.3- Policies and Procedures

Criteria

The registered person makes available to staff a comprehensive policy and procedure file. The policy documents cover all aspects of work including practical task, administrative tasks and legal/ethical responsibilities such as Health and Safety (legal), promoting dignity (ethical). The documents underpin all staff practice and provide a framework from which service is delivered. All policies and procedures should reflect current legislation and practice for the Isle of Man. The registered manager sets in place recorded systems to ensure the staff team are familiar with and comply with the policy documents whilst at work. People living at the home can ask for access to the policy and procedure documents. (A list of mandatory policies and procedures is available in Appendix A).

Our decision
Compliant

Reasons for our decision
Files containing general policies and procedures were available in the home's office. HR polices were kept in a separate file. Staff signing sheets were in place behind each policy. Staff had been instructed to sign to evidence that they had read and understood them.

Staff also said that they were informed by the ASRSW whenever a policy and procedure had been updated / amended.

Requirements and recommendations
None

Provider's action plan
Not applicable

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 7.8 - Quality Assurance Systems

Criteria

Formal quality assurance systems are in place and the registered person uses a range of tools to measure the quality of the service provided. This will include:

- **numbers and types of complaints received and any learning resulting from this;**
- **comments and compliments about the service from a range of stakeholders and any actions taken as a result of stakeholder feedback;**
- **accident and incident reports;**
- **observations of those using the service;**

- **views of staff working at the service;**
- **reports from the responsible person's visits to the home (or their nominated person) which must include the notes of the visits.**

Our decision
Compliant

Reasons for our decision
Formal quality assurance systems were in place to measure the quality of the service provided, including:

- a complaints book
- questionnaires for staff, visitors and residents were provided by the front door
- accidents and incidents were recorded and notifications sent to the Registration and Inspection Unit for any event that affected the well-being of a resident
- regular team meetings and supervisions recorded the views of the staff working in the home

Requirements and recommendations
None

Provider's action plan
Not applicable

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 7.9 - Annual Reports

Criteria

An annual report lists the success of the service and introduces a written development/improvement plan based on the outcomes of the quality assessment exercise. The plan is displayed and available to all. The annual report could include:

- **achievements in the year;**
- **plans for the future;**
- **outcomes of the quality assessment exercise;**
- **medication audits;**
- **equipment audits;**
- **care plan audits and;**
- **compliments and complaints received and any changes made as a result of concerns raised.**

Our decision
Compliant

Reason for our decision
A Cushag House Annual Report & Plan 2017 was displayed by the front door of the home. This

contained sections on:

- Service User's achievements in the past year
- Involvement of family / friends to service plans
- Changes to Cushag House building or outside area
- Staffing
- Audit outcomes from finance and compliance and a pharmacy audit
- Compliments and complaints
- Accidents and incidents
- Feedback / comments about the service
- Areas of good practice
- Future plans

Requirements and recommendations
None

Provider's action plan
Not applicable

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Previous requirements not met / Other Areas Identified during this inspection

Previous requirements not met
Standard 2.1
Chipped paint on a column in the dining room.
Not met
Carried over 10 May 2017
Timescale: August 2017

Standard 2.10
Getting up and going to bed times should be recorded in a support plan.
Not met
Carried over 10 May 2017
Timescale: These were completed subsequent to the inspection.

Standard 3.19
Skills, needs and risk assessment documents should be completed correctly to reflect an individual's personal intervention plan.
Not met
Carried over 10 May 2017
Timescale: These were completed subsequent to the inspection.

Standard 7.4
Policy and procedures should be regularly reviewed.
Not met
Carried over 10 May 2017
Timescale: August 2017

Standard 7.14
Twice yearly written reports should be produced following a quality assessment in relation to the premises, staffing levels and skills, resident satisfaction and records
Part met
Carried over 10 May 2017

Timescale: December 2017

Other Areas Identified during this inspection

Standard 2.1
Food stains on dining room ceiling need removing.
Timescale: August 2017

Provider's action plan
2.1 These works have been requested for completion by Government Estates Services Directorate.

7.14 One internal audit has been completed by the Quality and Performance Improvement Manager covering these areas.
One internal audit from the service manager has been undertaken, however does not cover these areas: service manager audit will be reviewed and updated to cover these areas.

7.4 These are presently in the process of ongoing update through the Quality and Performance Improvement Manager.

Please complete the provider action plan sections beneath each requirements and recommendations providing details of action taken (or to be taken) with timescale for each.

The inspector would like to thank the management, staff and service users for their co-operation with this inspection.

If you would like to discuss any of the issues mentioned in this report please do not hesitate to contact the Registration and Inspection Unit.

Inspector: Kevin West **Date:** 2/6/17

Part 5 Provider's comments/response

To: The Registration and Inspection Unit, 3rd Floor, Murray House, Mount Havelock, Douglas IM1 2SF

From: Cushag House

I / we have read the inspection report for the unannounced inspection carried out on 10 May 2017 at the establishment known as Cushag House, and confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s). ☒

I/we agree to comply with the requirements/recommendations within the timescales as stated in this report. ☒

Please return the whole report which includes the completed action sections to the Registration and Inspection Unit within 4 weeks from receiving the report. Failure to do so will result in your report going on line without your comments.

Or

I/we am/are unable to confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s)

x☐

Click here to enter text.

Signed
Responsible Person Nick Smith Service Manager.
Date 12/06/2017

Signed
Registered Manager Nicola Ogden ASRSW
Date 12/06/2017.

Action plan/provider's response noted and approved by Inspector: Kevin West
Date: 14/6/17 **Signature/initials:** K.W.