Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City South 1
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	07 July 2022
Centre ID:	OSV-0003695
Fieldwork ID:	MON-0037388

About the designated centre

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

The designated centre provided residential accommodation, on a seven day basis or five day basis, to adults diagnosed with a mild or moderate intellectual disability.This centre offered a residential service to 22 residents and a respite service that could accommodate three residents.The centre consisted of three residences which were based on the outskirts of a city, two of which were located side by side. All residents attended day services and occupation and many went home at weekends and holidays to their families. The first residence was situated in a quiet housing estate. This house opened on a monday to friday basis and the house accommodated eight male and female adult residents. The premises consisted of eight single bedrooms, two of the bedrooms were for regular respite residents. The living area had two large sitting rooms and a large communal kitchen and dining area. There was one staff bedroom / office and a large laundry / utility room. There were two bathrooms and one separate toilet facility. The second residence provided residential and respite accommodation to seven adult males. It was one of two detached residences which was situated in the city environs adjacent to a day service. The residence consisted of eight individual bedrooms and a separate staff bedroom. Seven residents lived at this residence and the eighth bedroom was used for respite purposes. The living area had a sitting room and a large communal dining area off a modern kitchen with a separate utility room. A small visitors and music room was situated at the back of the house. The third residence provided residential accommodation to nine female adults. It was the second of the two detached residences, situated in the city environs. The residence consisted of eight individual bedrooms upstairs and one bedroom downstairs. The living area had a sitting room and a large communal dining area off a modern kitchen, with a separate utility room and an office, downstairs. All houses had gardens to the front and all rear gardens were well maintained and secured.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 7 July 2022	10:00hrs to 15:00hrs	Lucia Power	Lead

What residents told us and what inspectors observed

On the day of inspection there was only two residents in the centre as the others were at their day services.

On arrival at the centre there was a delivery being made to one for the houses which made up part of the designated centre. The inspector observed staff carrying out the necessary COVID-19 checks. The inspector introduced themselves and staff followed the same protocol pertaining to COVID-19 checks. A resident was sitting having their breakfast and staff were seen to engage in a very respectful manner. The resident looked happy and content and was seen to be very comfortable in their environment. In the house next door there was a resident watching television and they appeared to be very happy in their own company. A staff member was working in another room and was seen to be respectful of this resident's space, but also demonstrated a good knowledge of their needs.

This inspection was unannounced and a follow up from the previous inspection carried out in October 2021, the purpose was to review the provider's compliance plan and assurances that they had given to the chief inspector about their commitment to come into compliance with the regulations as outlined in the Health Act 2007 (as amended), therefore this inspection had a particular focus and the inspector specifically reviewed the areas that were not compliant in the last inspection and also the provider's updated actions relating to the compliance plan which was submitted to HIQA in February 2022.

The provider had committed to have regular meetings with the residents and had assured HIQA that the person in charge would attend monthly advocacy meetings and that actions from these meetings would be placed on the agenda for monthly meetings between the person in charge and the person participating in management. The inspector reviewed meetings from January 2022 to July 2022 and noted that monthly meetings were not taking place in a consistent manner. Furthermore it was noted where residents had raised issues such as privacy there was no record of follow up actions especially where an issue was raised on an ongoing basis by the residents.

It was also noted that due to the behaviours of a resident, other residents were impacted and was documented in behavioural plans and other meeting notes. This will be discussed in the next two sections of the report where the governance and management of the centre was reviewed and how these arrangements impacted the lived experience for residents.

Capacity and capability

This inspection was an unannounced inspection and the primary focus was follow up on the compliance actions that the provider committed to improving. From the findings of this inspection it was found that the provider failed to follow the actions outlined in their compliance plan and also did not demonstrate effective governance management and oversight of this centre. The inspection in October 2021 found the provider to be not compliant in governance and management and due to repeated non-compliance with this regulation, the provider was issued with an urgent action on the day of inspection.

On the day of inspection, the inspector sought the provider's annual review and six monthly audits, this is a requirement under regulation 23 cited under part 7 management and control of operations in the Health Act 2007 (care and support of residents in designated centres for persons (children and adults) with disabilities) regulations 2013. These reports were not available initially, but the person in charge verified that the audits had taken place. The inspector was advised that the annual review was completed in June 2022 and the six monthly visit in February 2022. At the end of the inspection, the six monthly visit reports was located and this was reviewed after the inspection.

From a review of the provider's audits, issues pertaining to governance and management was outlined in the reports and a number of regulations that required review. Despite these findings there was no live action plan in place, no evidence of review and no evidence of how the provider was going to come into compliance with the findings. Protection was not reviewed in the provider's audits and given this was found not compliant in the last two HIQA inspections, the provider did not demonstrate that they were working towards improving protection as outlined under the regulation for residents. This will be discussed further on in the report under quality and safety. Due to the findings on the day of inspection a second urgent action was issued under regulation 8 protection.

Staffing was found not compliant in the last inspection, however the provider had put in place staffing in line with their current statement of purpose. On the day of inspection staffing was in line with the assessed needs of residents. This was evidenced by reviewing the staff rotas and also in discussion with the PIC.

The provider has committed to ensuring a training plan was in place for this centre and that all staff would complete the online safeguarding training. On the day of inspection there was gaps in relation to the training of staff and there was no training plan in place as committed to by the provider. In the updated actions put in place arising from the compliance plan, the provider advised that all training would be planned and completed by 29th May 2022. From a review of the training schedule there was a number of training areas that were not completed. For example, seven staff required fire safety training and four staff required managing behaviour that challenges. Furthermore, seven staff required safeguarding training and there was no evidence provided to show that all staff had completed the online safeguarding training as committed to by the provider in their compliance plan.

The last inspection found that staff did not have access to appropriate supervision which they had requested. The findings on this inspection found that no supervision

meetings with staff had taken place and no evidence to show meetings had occurred was offered. The provider has a policy in place pertaining to performance management, this policy outlined that staff would receive an annual performance review, however these reviews had not taken place in line with the provider's own policy.

Regulation 15: Staffing

The Provider was ensuring there was staffing in place in line with the assessed needs of residents. This was reflected in the provider's statement of purpose and rotas.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge did not ensure that staff had access to the appropriate training and had not adhered to their commitment to develop a training plan as per their updated provider compliance plan. There was no evidence that staff were appropriately supervised or evidence to support this was offered. The provider did not adhere to their own policy in relation to performance and appraisals and there was no evidence that these had taken place.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured effective management arrangements were in place within the centre to ensure residents received both a safe and effective service that was appropriate to their needs and consistently monitored.The provider did not adhere to their compliance plan submitted to HIQA following the October 2021 inspection and subsequent updated action plan of February 2022. The provider did not ensure there was effective oversight in relation to the regulations found not compliant in the last inspection and the provider audits did not have an action plan in place to review and monitor how they were going to make improvements to come into compliance. There was no effective arrangements in place to support, develop and performance manage staff.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had an updated statement of purpose in place containing the information as set out under schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge did not notify the chief inspector of incidents in the centre that had an adverse impact on the lived experience of residents. This was also not complaint in the previous inspection.

Judgment: Not compliant

Quality and safety

The inspector found that there was little improvement since the last inspection to ensure the care and welfare and quality and safety of residents. There was improvements noted in premises and refurbishments had taken place. On the previous two inspections the provider was found to be not compliant in regulation 5, regulation 8 and regulation 9, on this inspection these findings remained the same.

The provider through their compliance plan had provided assurances to HIQA that they would come into compliance and that there would be an annual person centred care review for each resident. On the day of inspection the same issues that were noted in the October inspection remained outstanding with limited progress. Six resident personal files were reviewed and the inspector found that annual goals were not updated and did not reflect residents' choices . Furthermore, previously identified goals remained outstanding from 2019, 2020 and 2021. Where goals had been identified they were meaningful in nature, and related to ongoing activities such as visiting family and friends, hoovering and going to religious mass. It was also noted that there was to be key worker meetings with residents on a monthly basis, these did not consistently happen, and where they had , discussions centred more on medical appointments as opposed to progress with personal goals .

As previously referred to in this report protection remained not compliant from the previous two inspections, it was also not an area reviewed by the provider in their internal audits and given the ongoing issues pertaining to non-compliance it did not

demonstrate a commitment from the provider to come into compliance.

On the day of inspection the inspector reviewed a number of files and noted that four incidents had occurred which impacted the lived experience for residents. It was documented by the provider that another resident was shouting and this was having an upsetting impact for residents living in this house. These incidents were not followed up and there was no actions to demonstrate how the provider was going to support the other residents. The provider was also to inform the chief inspector within three working days of any adverse incident in the centre, these notifications were not sent in as required by the regulation, and this issue was also noted in the October inspection where the provider was found not complaint in notifications.

It was also further noted from a review of the residents' meeting, that residents had voiced their concern that another resident was going into their rooms and that they didn't like it, this was noted at a few meetings, but there was no action plan or follow up noted on how the provider was going to address the residents' concerns.

From discussion with the person in charge they were asked why the provider had not submitted notifications as was required by the regulations. The inspector was advised that they were not deemed as peer to peer abuse, but that there was ongoing case reviews to discuss the situation. The inspector requested a copy of the case reviews, but was advised these were held off site. Once these records were made available, the inspector reviewed the notes and found that a staff member had flagged that what they had witnessed was horrendous as a resident was very loud and intimidating, it was also noted that another resident was spending a lot of time in their room because of another resident's behaviour and that this resident had high blood pressure and was getting upset.

The inspector reviewed the interim safeguarding plans that were in place and noted they did not reflect the current situation presenting in the centre and that they were not updated according to reflect the support needs of residents. The provider in their compliance update had verified to HIQA in February 2022 that there was no current active safeguarding plans in place and that all future safeguarding incidents will be actioned immediately. This action was not in place and evidence on the day demonstrated that the provider had not ensured the safety of residents.

Regulation 17: Premises

The designated centre was laid out to meet the needs of residents and there had been improvements since the last inspection and a kitchen fitted in one of the houses. There remained some areas that required improvement such as rust on radiators.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had not ensured that personal care plans were up to date and that an annual meeting had taken place with the residents to explore their goals. There was no improvements noted in the personal plans since the last inspection and the provider did not deliver on the commitments they made to come into compliance with the regulation. Key worker meetings were due to happen monthly as per the providers format, meetings were not consistent and reviews were based on medical appointments. The provider did not demonstrate a person centred approach that maximised the participation of residents.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured residents were protected from all forms of abuse.Safeguarding plans were not updated to reflect the impact to residents and there was no evidence to show that all staff had completed safeguarding training and this remained outstanding . In the previous compliance plan the provider had committed to training staff to complete preliminary screening forms and developing interim safeguarding plans. There was no evidence to support this was actioned by the provider and the person in charge verified this has not happened. The provider had not reviewed this regulation in the last two provider internal audits which demonstrated lack of oversight pertaining to the protection of residents.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had committed to put in place regular meetings with residents, however these were not consistent and actions were not followed up where residents highlighted an issue. The provider had also committed to exploring advocacy but there was no evidence to support this was followed through. The provider had not ensured that each residents privacy was respected despite residents voicing this at residents meetings and individually telling staff on duty.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City South 1 OSV-0003695

Inspection ID: MON-0037388

Date of inspection: 07/07/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The person in charge has devised a schedule of all staff performance management, all staff will have their performance appraised by 30th August 2022. The person in charge will also support staff with additional supervision meetings during the year if this is necessary • The person in charge will ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. • The Person in charge will put a training plan in place for necessary training to be completed. The person in charge has arranged the following: 1. Staff are booked to attend fire training on July 28th, all staff will have completed fire training by 30th August 2022 2. PBS training has been booked, all staff will have completed training by 6th September 2022 3. Manual handling training dates have been booked for staff, all staff will have completed training by 30th September 2022 4. All staff currently working in the designated centre have completed safeguarding vulnerable adults training this was completed by July 10th	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
• Through Performance Management Review the person in charge will meet all staff to support them to effectively exercise their personal, professional and collective accountability for the provision of effective and safe care and supports.
• All staff will be provided with access to support as well as development opportunities, and their performance will be appraised by 30th August 2022. Staff have been sent a copy of the Performance Management Review Form and given a date for this review, a written record will be maintained of each supervision, support and performance appraisal, and a copy will be given to the staff member to support, develop or manage all staff to exercise their responsibilities appropriately. The record will be signed by the person in charge and staff member at the end of each appraisal and will be available for inspection.
• The person in charge has scheduled monthly staff meetings from July to December 2022.
• The person in charge has scheduled monthly residential forum meetings from July to December 2022. A staff member has been identified to support the residential forum meetings.
• The Provider will ensure that annual reviews and six-monthly unannounced visits are carried out on schedule and that there is a copy made available to residents and staff.
• Report of quality and safety of care and support as outlined in the annual review completed on 08.06.22 will be put into practice via an action plan, will become a working document and will be in place by the 7th August 2022. This working document will be discussed at monthly staff meetings.
• The PPIM has scheduled monthly meetings with the person in charge and will be in regular phone contact to ensure that management systems are in place that will assure the Provider that service provided is safe, appropriate to residents' needs, consistent and effectively monitored. If further meetings are required, the PPIM and person in charge will schedule on an ongoing basis.
• The PPIM will visit the designated centre on a monthly basis to ensure that there is evidence of learning and improvement brought about as a result of the actions from annual reviews and unannounced visits
• There is a standard Compliance Plan tracker in place across all designated centres that the Provider has full access to and monitors regularly.
• There is regular meetings between the PPIM and the Chief Operations Officer during which compliance with regulations is an agenda item.
• The COO and the Provider discuss compliance with regulations at the monthly meeting of the Board of Directors.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC/PPIM will ensure that all notifications in relation to adverse incidents, any allegation, suspected or confirmed abuse of any resident that had occurred in the

designated centre are reported in a timely manner (within 3 working days).

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The person in charge has scheduled a maintenance review of the designated centre with the facilities manager to establish works to be carried out. • Once established a schedule to complete these works will be completed and agreed by 30th September 2022, all works have been logged in Cope Foundations maintenance request system by PIC	

Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • The person in charge has scheduled Person Centered Planning (PCP) meetings for those residents whose personal plans have not been reviewed, together with each resident and, with his or her consent, their representative staff/key worker will identify their strengths, needs and life goals, meetings will be completed for all residents by 30th September 2022. • Monthly residential forum meetings have been scheduled commencing in July 2022, these meetings will be facilitated to ensure that residents are given the opportunity to become more involved in decision-making processes around their daily lives to so that they are actively involved and given the freedom to exercise autonomy, choice and independence • The person in charge as part of staff's Performance Management Review will 1. Ensure that all staff are informed that they are accountable for the evaluation and updating of resident's care plans. 2. Ensure that all resident's capacity to exercise personal independence and choice in their daily lives, with routines, practices and facilities promoting resident's independence and preferences is discussed and documented in their personal plan as part of their PCP • The person in charge will add the updating of care plans to the agenda of monthly staff meetings to ensure oversight and monitoring.	

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The provider will ensure that this regulation is reviewed as part of annual reviews and six-monthly unannounced visits
• All staff currently working in the designated centre have completed safeguarding vulnerable adults training
• The PIC has retrospectively notified the regulator of all incidents where it is deemed that there is an allegation or suspicion of abuse by a resident in the designated centre
• The Designated Officer has visited the designated centre, the following actions have been agreed:
1. Preliminary screening forms (PSF1) and updated interim safeguarding plans will be submitted retrospectively to HSE Safeguarding for all incidents reported to the regulator by 7th August 2022
2. The Designated Officer has committed to in person bi-monthly safeguarding review meetings with the person in charge commencing on 16.08.2022
3. Issues of concern regarding a specific resident will be addressed under the organisation's case conference structure next review 24.08.2022
4. The CNS in Behaviour has completed a Reiss screen and will be available to discuss the results/mental health concerns with resident of concern's family members. Referral to Psychiatry following screening and discussion with family if deemed necessary.
5. The CNS in Behaviour and staff are completing a compatibility study, this will examine the impact of residents behaviour on that of his peers within the designated centre, findings from this study will be escalated to the Provider to ensure that all residents are protected from all forms of abuse. Following compatibility study a meeting will be called to discuss the outcome. Progress of this process will be reviewed by Friday 14th October 2022.
6. Safeguarding to be added as an agenda item to monthly staff meetings to ensure consistency of reporting of all issues of concern in resident notes, NIMS and safeguarding plans
• The PIC/PPIM will ensure that all notifications in relation to adverse incidents, any allegation, suspected or confirmed abuse of any resident that had occurred in the designated centre are reported in a timely manner (within 3 working days).

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The person in charge has scheduled monthly residential forum meetings from July to December 2022, a staff member has been identified to support the residential forum meetings.

• Residents have access to advocacy services and information about their rights, easy read information will be provided to residents at monthly resident forum meetings to ensure that residents know their rights
• The person in charge will discuss resident's rights at all monthly staff meetings to ensure that staff understand these rights and that they support residents to exercise their rights.
• The person in charge will audit the minutes from monthly residential forum meetings to ensure that the culture within the centre encourages regular feedback from residents and this feedback informs practice.
• The provider will ensure that evaluation of the effectiveness of practices to support resident's rights, forms part of the six-monthly and annual reviews, in compliance with the regulations.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/09/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/08/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2022
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/08/2022

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/12/2022
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional	Not Compliant	Orange	30/08/2022

	responsibility for the quality and safety of the services that they are delivering.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	10/07/2022
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	30/09/2022
Regulation 05(6)(c)	The person in charge shall ensure that the	Not Compliant	Orange	30/09/2022

	personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	30/09/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	14/10/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care,	Not Compliant	Orange	10/07/2022

	professional consultations and personal information.			