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 North 15
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	08 May 2023
Centre ID:	OSV-0005395
Fieldwork ID:	MON-0032207

About the designated centre

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

Cork City North 15 is comprised of 3 purpose-built bungalows which are located within a secure campus setting adjacent to another designated centre and a day activation centre on the outskirts of cork city. The designated centre can provide full residential care for up to 17 adult residents. Two bungalows are comprised of six individual bedrooms, kitchen, dining and sitting room, music room, laundry and linen room. Each bungalow also has two shared bathrooms and an additional toilet for residents to use. There is a connecting corridor between two bungalows where a staff office and facilities are located. The third bungalow has been restructured to create one self-contained apartment styled dwelling to support one resident and the rest of the bungalow can support a maximum of four residents. The centre supports residents with mild, moderate and severe/profound levels of intellectual disability with many residents presenting with additional complex needs and behaviours that challenge. Residents are supported by a staff team that comprises of both nursing and social care staff by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
Monday 8 May 2023	10:10hrs to 17:30hrs	Elaine McKeown	Lead
Monday 8 May 2023	10:10hrs to 17:30hrs	Deirdre Duggan	Support

What residents told us and what inspectors observed

This was an unannounced focused inspection of the designated centre to ensure the residents were being supported to have a good quality of life in a safe environment while being supported as per their assessed needs.

This designated centre comprised of three purpose built bungalows located on a campus setting. These bungalows were located close together on the same grounds as an activation centre with two of these bungalows interconnected. The third bungalow was interconnected to another bungalow that was part of another designated centre operated by the same provider. These three bungalows had a capacity for between five and six residents each giving the centre an overall maximum capacity of 17 residents. On the day of inspection 14 residents were present in the centre, nine of whom were met by inspectors.

Inspectors visited all three houses at different times during the inspection which did not impact on residents' routines or planned activities. Staff advised the inspectors of suitable times which enabled the inspectors to meet and interact with the residents during the day.

At the start of the inspection one inspector was able to briefly interact with two residents in the dining room of their home while they were enjoying their breakfast. Later in the morning another resident returned to the house and the inspector had an opportunity to speak with them. This resident spoke about their life in the centre and the things they enjoyed to do. The resident liked to assist staff with regular chores in the house and designated centre. They also told the inspector about some of their goals and their keen interest in sports and luxury cars. While chatting with the inspector the resident occasionally sought support/reassurance from staff. The inspector observed the staff to provide support but encourage the resident to answer the inspector themselves rather than answer for them.

However, during a walk about of this house the inspector observed a number of environmental restrictions which included a locked kitchen door. Staff explained that the door was usually kept locked. The rationale documented was for the restriction to be in place when a particular resident was in the house. The restriction was observed to remain in place when that resident was not in the house. This will be further discussed in the quality and safety section of the report.

Another inspector was introduced to three residents in the sitting room of their home during the morning. Two of the residents communicated without words. However, the staff on duty were familiar with how each resident communicated their preferences and wishes with personal gestures. The residents were also observed to respond to staff with sign language and smile when staff outlined the planned activity for the morning to the residents which included going for a walk and attending the day service located on the campus.

One resident in the house engaged with the inspector and the staff present, talking about meeting their family representatives. The staff were observed to assist the resident in a respectful manner to explain to the inspector what activities they liked to take part in, which included visiting outdoor areas such as a wildlife park. The resident was very happy to show the inspector photographs of important events and friends with whom they liked to spend time with. They also proudly showed the inspector their bedroom which contained a number of personal possessions and photographs which were very important to the resident.

The inspector was informed that two residents had already left to attend their day service before the inspector arrived. Another resident was observed to be supported to have their breakfast in the dining room after they had completed their morning routine. The inspector noted that this resident rocked back and forth on their chair which created some noise. Staff and residents present in the house at the time did not appear to notice this noise. Staff explained this activity did not appear to adversely affect the other residents in the house. Due to the preference of the particular resident to eat their meals later than their peers, the other residents were not usually present in the dining room when this resident was being supported by staff to have their meals.

There were three residents being supported in the third house at the time of this inspection. An inspector met one resident who was being supported by a dedicated staff member in the music room in the afternoon. This resident appeared relaxed and responded with minimal gestures to the inspector. They were later observed in the dining room enjoying a snack. This resident had previously been supported in the self-contained apartment in the same house but had moved back to the main house in the Summer of 2022 due to declining health. Staff explained since the resident's return to the main house they were accessing more of the communal areas and reported to be happy.

Another resident had moved from the main house into the apartment. Staff had consulted with family representatives prior to the transition. However, family representatives for the resident living in the apartment at the time of this inspection had expressed some concerns for the resident. In the annual report in September 2022, the space in the apartment was described as small with "no room for the resident to wander around" by the family representatives. This issue will be further discussed in the quality and safety section of the report.

Staff outlined activities which the residents enjoyed attending regularly which included swimming. Prior to the pandemic residents had attended a few times each week. However, the frequency had not returned to pre-pandemic levels. In recent months residents were being supported to attend once a week, occasionally a second session might be available. The inspector was informed that due to circumstances outside of the provider's control, no swimming activity would be available for a number of weeks in the provider's campus based swimming pool due to a lack of lifeguards being available. Staff explained some of the residents would be able to access a nearby public pool. However, not all of the residents in this designated centre who enjoyed swimming would be able to access the public pool due to their assessed needs such as requiring a hoist transfer to get into the water.

The inspector was informed suitable alternative activities were being considered at the time of this inspection.

Staff spoke of the different preferences and interests of the residents living in the house. These included going to the cinema, restaurants and going on holidays. For example, three residents had being supported to have an overnight stay in rented accommodation. It was located near a quiet beach where the residents could enjoy walks. Two residents really enjoyed the experience, however, staff explained one resident appeared unsettled. The staff felt it would be more enjoyable for that resident to be supported to participate in day trips during 2023 rather than overnight stays in –line with their preference to maintain their daily routine. The development and progression of personal goals will be further discussed in the quality and safety section of this report.

The inspectors were informed that one resident had been admitted to the designated centre in March 2022. This resident was met by one of the inspectors during the day. Staff explained the preferred daily routine for the resident which included resting after their breakfast before going to their day service. The resident was observed to be resting on a couch in the sitting room when the inspector arrived. Staff outlined how the resident had settled into their new home well and engaged in activities such as bowling & karaoke with their peers. They were also supported to have regular contact with family representatives by phone and visits.

This designated centre had previously been inspected in May 2022. A number of actions had been identified during that inspection which related to fire safety and premises. These actions had been addressed as outlined in the compliance plan response submitted by the provider to the chief inspector. However, one fire door in a utility room did not have a working self-closing mechanism on the day of the inspection. A laundry basket was observed to be in place holding the door open. This was removed immediately once an inspector brought the issue to the attention of the person in charge. The self-closing mechanism was repaired during the inspection.

An inspector also observed the extension panel on the fire door to a bedroom was opened back in the same house. The resident was resting on their bed at the time. Staff advised the resident did not like their bedroom door being open and the extension panel was opened back to enable staff to monitor the resident. However, this adversely impacted fire safety as an effective closure to the bedroom could not be attained with the extension panel opened back if the fire alarm was activated. The inspectors were informed of controls in place at the time of the inspection due to recent damage occurring to two other fire doors in the self-contained apartment. Issues that were identified relating to fire during this inspection will be further discussed in the capacity and capability section of this report.

There was evidence of improvements in the décor and furniture in two of the houses. The provider had purchased new dining room furniture which included tables, chairs and sideboards. This assisted to provide a homely atmosphere. General maintenance and upgrade works of bathrooms had also taken place since the previous inspection. The person in charge outlined plans to address general

maintenance issues in the remaining bungalow in the months following this inspection.

Throughout the inspection staff were observed to interact warmly with residents and were familiar with their support needs and communication styles. Staff were very knowledgeable about the residents they supported. They presented as caring and committed in their roles.

In summary, there was evidence of ongoing upgrade of décor and maintenance in the designated centre. Residents were being supported by a dedicated staff team. There was a person in charge whose remit was over this designated centre. The provider was actively seeking to address staff vacancies in the designated centre. However, the use of relief staff and the skill mix available to support the assessed needs of the residents, staffing levels were not consistently maintained in line with the statement of purpose. In addition, not all residents' personal goals were specific, measurable, achievable, relevant and time-bound (SMART). Inspectors were also not assured all residents' rights were consistently supported in the designated centre. This included the use of restrictive practices in one of the houses which was not required for all of the residents living in the house.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being provided.

Capacity and capability

Due to concerns in relation to Regulation 23 Governance and Management, Regulation 15 Staffing, Regulation 16 Training and development, Regulation 5 Individualised assessment and personal plan and Regulation 9 Rights, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in October 2022 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan, the provider has provided an action plan to the Chief Inspector highlighting the steps the provider will take to improve compliance in the provider's registered centres. These regulations were reviewed on this inspection and this inspection report will outline the findings found on inspection.

The provider had appointed a person in charge in January 2023, whose remit was over this designated centre. The person worked full time and was supported in their role by the previous person in charge who remained in their role for an adjacent designated centre on the campus. This person also provided information to the

inspectors and assisted with facilitating the inspection. There was also evidence of ongoing support from the person participating in management. This included regular meetings with the person in charge and a review of the statement of purpose to ensure it accurately reflected the services and facilities provided in the designated centre. The person in charge was aware of their role and responsibilities. They also provided front line support to the staff team. They regularly met with all staff members working both on the day and night shifts. In addition, they outlined plans to attend community activities with residents to ensure they were familiar with all the supports required by the residents and staff team.

The inspectors were informed that there were six whole time equivalent (WTE) care staff vacancies in the designated centre at the time of this inspection. To address the lack of core staffing resources the provider had engaged the services of regular relief staff from an internal panel of staff and two external agencies (staff sourced from external agencies to the provider). Family representatives of one resident had informed the auditors of the annual report in September 2022 that the lack of familiar and consistent staff was having an adverse impact on their relative. The resident did not respond well to changing routines and to staff who were not familiar or experienced in supporting the specific needs of the resident. However, in recent months regular staff have been available to support residents in the designated centre. The person in charge informed the inspectors of a compliment received from another family representative in the days before this inspection. They had observed in recent months that their relative was being supported by a consistent group of core staff and the team were displaying a positive approach to ensuring the needs of their relative were being met.

The provider had implemented a system at the end of 2022 to support the person in charge to maintain consistent staffing levels. The person in charge submitted a weekly agency staff request to support gaps in staff resources, facilitating staff training and planned leave. However, due to the ongoing issues with staffing resources, the skill mix of staff was not being consistently maintained in this designated centre. For example, the day before this inspection only one nurse was on duty during the day in the designated centre. The statement of purpose outlines the skill mix required on each shift. Two nurses are required to be on duty during the day in the designated centre to meet the assessed needs of the residents. The clinical nurse manager, (CNM) was the only nurse on duty for the day. This situation had occurred due to the unexpected absence of another nurse rostered on duty. The inspectors acknowledge that the provider had allocated a relief social care staff to the designated centre for the shift to provide support to the residents. The inspectors were also aware that the person in charge had been required to provide front line support on a number of occasions in the weeks prior to this inspection to maintain minimal staffing levels due to unexpected absences of staff.

The provider was aware of gaps in the mandatory training of staff within the designated centre. The person in charge had a training matrix which indicated that training was provided to staff in a number of areas such as fire safety and infection prevention and control (IPC). However, not all mandatory training had been completed. For example, there was training available in both positive behaviour support (PBS) and managing actual and potential aggression (MAPA). A number of

the regular staff team had completed one or both of these training sessions. However, records showed that 37% of staff had not completed this training or else were overdue refresher training in this area. There were also gaps identified in mandatory training in a number of other areas, including safeguarding of vulnerable adults and manual handling. The person in charge showed the inspectors a training contingency plan that was in place to address the deficits in training that had been identified. As previously mentioned some agency staff worked in this centre. While records relating to a number of these staff were maintained on site, the management of the centre were unclear about what training had been completed by some of these staff and did not have oversight of all of these records.

As previously mentioned this designated centre was inspected in May 2022, with a number of actions identified. The provider had responded with a compliance plan that was accepted by the chief inspector. One of the actions included a new fire safety maintenance log which staff were to complete if an issue arose in the designated centre relating to fire safety. The inspectors reviewed this log during the inspection. While the issue relating to the damaged glass panel on two fire doors was logged, there was no reference to the faulty self-closing mechanism in the same house. During the walk about with the person in charge, as already mentioned in this report, a laundry basket was being used to keep a utility room door open. This was an obstruction, preventing the effective closing of the door in the event of the fire alarm activating. The person in charge was not aware the mechanism was not working on the door, but ensured the issue was addressed immediately. One inspector ensured this mechanism was effectively working when visiting one of the residents in the afternoon before the inspection ended.

The inspectors acknowledge that the provider had put additional fire safety controls in place to ensure the ongoing safety of one resident living in the self contained apartment. Due to a delay outside of the provider's control to replace damaged fire resistant glass panels on two doors in the apartment, interim measures were put in place. These included, no cooking in the apartment kitchen until the fire doors were repaired. There was also waking staff on duty at all times day and night.

However, an inspector observed two bedrooms with extension panels on the fire doors in the opened back position. The inspector was informed one door was in this position to ventilate the room while the resident was not present. The bedroom window was also observed to be opened at the same time. As previously mentioned in this report the second bedroom was occupied by the resident who was sleeping. The inspector was informed that the resident did not like the bedroom door to be opened back using the magnetic system. Routinely staff opened back the extension panel on the fire door so they could observe the resident without disturbing them. However, neither of these fire doors would effectively provide safety from the effects of a fire if the fire alarm was activated. This was discussed with the staff present in the house and during the feedback meeting at the end of the inspection.

Another issue identified during the inspection related to environmental restrictions in place in the designated centre. While the person in charge had notified the chief inspector of the restrictions that were in place, the inspectors were not assured of the rationale for some of the restrictions which impacted residents accessing a

number of areas in their homes. These including the kitchens, the laundry rooms, the linen rooms and some storage areas. While there was clear rationale in place for some of these restrictions, others were seen to be historical in nature, with little evidence or rationale to demonstrate why they remained in place. For example, documentation viewed in relation to a restriction on accessing the kitchen in one house showed that this was in place to support one resident and that the kitchen door would be open when this resident was not in the house. However, an inspector observed that the kitchen door was kept locked when this resident was not present and the staff working in the centre confirmed that it was kept locked most of the time. This restriction did not allow other residents to access all areas of their home or to freely access food and beverages independently if they so wished. While the inspector did not observe this impacting in a negative manner on the residents present during their time in the centre, this was not in line with the plan in place. It also did not demonstrate efforts to minimise and reduce the restrictions in place for other residents. Restrictive practices were subject to regular review by the person in charge and the person participating in management with input from the staff team. However, the provider's internal rights committee had not reviewed the restrictive practices in this designated centre as per the provider's own policy and procedural guidelines.

Regulation 15: Staffing

There was a planned and actual rota in place. There was a core staff team available to support the needs of the residents. While there were staff vacancies at the time of this inspection, regular relief staff were available.

However, the skill mix of staff supporting the assessed needs of the residents was not always in –line with the statement of purpose and the size and layout of the designated centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had ensured a staff training and supervision schedule for 2023 was in place. There was evidence of ongoing review of the training requirements of staff within the designated centre.

However, while all staff had completed mandatory training in fire safety and IPC, not all staff had completed their refresher training in safeguarding and managing

behaviours that challenge.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had actively progressed with elements of their service improvement plan which was evident in this inspection. The provider had also addressed the actions identified in the previous Health Information and Quality Authority (HIQA) inspection. This included having systems in place for staff to ensure the ongoing safety of residents in relation to fire safety. However, on the day of the inspection, it was not evident that staff were documenting all issues pertaining to fire safety maintenance as requested by the provider.

Further improvement was required to ensure ongoing and consistent oversight of monitoring systems was maintained in the designated centre including the review of restrictive practices within the designated centre.

In addition, the skill mix of staff was not consistently maintained in the designated centre to support the assessed needs of the residents in line with the statement of purpose.

Judgment: Not compliant

Quality and safety

Overall, residents were being supported to receive person-centred care and support from a dedicated staff team. However, further improvements were required to ensure residents were supported to identify and attain meaningful goals. Some residents also required to have a robust review of their personal plans as per the findings of the annual review in September 2022. In addition, the provider was required to ensure the rights of all residents were consistently supported in the designated centre.

During the inspection staff were observed to speak respectfully about the residents living in the designated centre. Inspectors were informed of how residents were provided with choices in relation to the food that they ate, the clothes they wore and some of the activities that they took part in. Staff told an inspector that one resident liked to be smartly dressed and this resident was observed to be dressed in

this manner and proud of their appearance on the day of the inspection.

Some residents did not communicate using verbal speech but staff were clear on how these residents could communicate their preferences. Staff explained how they could determine if a resident was, for example, enjoying an activity. Staff told the inspector about taking a resident swimming and how the resident had communicated that they weren't enjoying the experience. Staff respected this and ceased the activity. Staff were considering how this activity could be approached in a way that would be more enjoyable to the resident as this activity had been recommended for this resident to aid in joint mobility.

The inspectors acknowledge that the documentation in place and templates being used in the personal plans of residents were improved from previous findings. This included easy-to-read information for residents relating to a number of topics including consent and COVID-19, complaints and allied health care professionals. However, not all documentation relating to personal goals was completed or had progress documented. For example, one personal plan had identified a goal of supporting the resident to experience new activities. This goal was only partially documented and had not been updated since June 2022. Other goals identified for residents were not clear. These included being supported to have familiar staff, being safe in their home and being happy. Another resident's personal goals had not been reviewed since December 2021. While one resident had a goal of moving to their new apartment which they had completed in January 2022.

Inspectors also discussed during the feedback meeting the inclusion of a goal for a resident relating to their independence with meal choices. While staff outlined the rationale behind this goal, the ongoing underlying medical condition for the resident would present limitations for the resident. Inspectors were not assured this was reflective of a personal goal as it was documented at the time of this inspection rather than a resident's right to be supported in–line with their assessed needs.

Inspectors were informed of the transition in the Summer of 2022 of two residents within one of the houses. A resident had moved into a self-contained apartment in January 2022. Communication notes reviewed consistently documented the resident was happy living in the apartment. The last entry in June 2022 had the same narrative. The next entry was December 2022 stating the resident was happy living in the main house. The person in charge outlined due to a decline in the health of the resident they required increased staff support and they were moved back into the main house. This has had a positive impact for this resident, including their increased use of communal spaces which they previously would not have enjoyed. However, the inspectors were not assured the resident who was moved into the apartment in July 2022 was being adequately supported in-line with their assessed needs.

While the provider had engaged with the family representatives and developed a transition plan for the residents, the space available for the resident living in the apartment at the time of this inspection was limited. The transition period was short in-line with the assessed needs of the resident. It was documented that the arrangement would be reviewed after two weeks. While this review did take place

there was limited evidence documented of consultation involving the resident. In September 2022, family representatives had raised concerns about the lack of space for the resident to wander around in the apartment, as the main house they had previously lived in was a large bungalow with lots of space. Staff reported to the inspectors that the resident was displaying less anxiety and behaviours that challenge than when they lived in the main house, however, they were not eliminated. On the day of the inspection, the inspectors did not get to meet this resident as they were resting in their bedroom at the time the inspectors were visiting. However, staff outlined how they supported the resident to access community locations regularly in-line with the expressed wishes of the resident. The person in charge also outlined a possible option to provide additional outdoor activities in a secure garden space at the side of the apartment for the resident.

Another issue that was raised by a family representative to the auditors of the September 2022 annual report regarded meal times in the designated centre. Their relative was no longer sitting with staff to have their meals which was an activity that they had previously enjoyed. It was not documented in the action plan of the annual report if or how this had been addressed by the staff team. In addition, another family representative outlined that not all staff were effectively able to communicate with a resident who communicated without words. While the person in charge endeavoured to have at least one familiar staff on each shift in each house, it is important that all staff are supported to be able to effectively communicate with the residents for whom they are providing support. The inspectors observed all staff on duty at the time of this inspection were able to effectively communicate with the residents they were supporting.

A complaint had also been made by a family representative in August 2022 regarding their relative's right to access their general practitioner at a time when they were unwell. While the staff team had ensured the resident was reviewed by an advanced nurse practitioner, the family representative was not satisfied with the care provided as the general practitioner did not come to review the resident. Subsequently the resident required admission to hospital. The provider held a case conference in November 2022 and the family representative was reported to be happy with the outcome.

Regulation 5: Individual assessment and personal plan

Not all residents personal plans had been subject to annual review at the time of this inspection, this had also been identified in the annual report of September 2022 recommending robust review of all residents personal plans.

Not all residents personal goals were documented as being progressed. Inspectors were not assured goals identified for some residents were effective and had been identified with the participation of the resident.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were being supported to access regular activities and day services in addition to community activities. The presence of restrictive practices for one resident impacting on other residents living in the same house to freely access the kitchen will be actioned under regulation 23: Governance and management.

While the provider had sought to address staffing resources some activities were being adversely impacted due to staffing resources at times, this included accessing community activities. In addition, the personal and living space for the resident living in the apartment required further review to ensure they had access to adequate space to meet their assessed needs.

Not all residents had been consistently supported to access professional consultations in a timely manner when required.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City North 15 OSV-0005395

Inspection ID: MON-0032207

Date of inspection: 08/05/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Recruitment is on-going to fill staff vacancies. • The PIC submits weekly agency requests to fill gaps. Regular staff are provided by the agency. These staff are familiar with the residents and their support needs. • Rosters are planned one month in advance and the PIC has oversight of all rosters. • The statement of purpose is currently under review to ensure that the appropriate skill mix required in the centre by day and by night is accurately reflected in same.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Local training matrix in place and the PIC regularly audits same. • All staff will complete safeguarding training on HSE-land. • Training schedule in place for the remainder of the year with dates booked for safety intervention training (managing behaviours that challenge).	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • The PIC has spoken to all team members in relation to appropriate documentation of fire safety checks. Regular fire safety audits continue and the PIC will ensure oversight of same to ensure that documentation is being completed in relation to daily and weekly checks. • The PIC will review the log of restrictive interventions in the centre and hold a team meeting to ensure that all staff are clear on what restrictive interventions are in place in the centre and the rationale for same. Regular restrictive practice audits will be completed to ensure that there are no restrictive interventions being used that have not been sanctioned and logged as per policy. • Recruitment is ongoing to fill staff vacancies. • The statement of purpose is currently under review to ensure that the appropriate skill mix required in the centre by day and by night is accurately reflected in same.	
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: • A comprehensive assessment will be completed for all residents. • The PIC will review all support plans with residents, keyworkers/ team members to ensure maximum participation of each resident in relation to their personal plan and identification of meaningful goals. • The PIC will then ensure that there is a schedule in place for annual review of each individual's personal plan with a named staff member assigned responsibility for same. • Easy read support plans for residents are currently being developed. • The PIC has arranged onsite training for staff in documenting and recording of care for care assistants. • The PIC and manager of adjacent centre have organized a schedule of workshops for all staff in relation to resident's personal plans, goals and appropriate documentation of progress of goals.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • 1 WTE activation staff has been recruited for the centre which will support residents to increase participation in meaningful activities outside the centre.	

• Management have met with staff around goals & documentation and the PIC will ensure regular auditing of all documentation pertaining to resident's activities and goals.
• The PIC will ensure that residents who require medical assessment or professional consultation will access same in a timely manner.
• The PIC has met with the PPIM and COO in relation to the resident living in the apartment and discussions were held around the suitability of the living arrangements for this individual long term. The PPIM and COO are exploring alternative options for the individual.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/11/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/10/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	30/11/2023

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/08/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30/09/2023
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	Substantially Compliant	Yellow	30/11/2023

	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.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/11/2023
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, professional consultations and personal information.	Not Compliant	Orange	31/12/2023