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 5 |
| Name of provider: | Horizons |
| Address of centre: | Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 11 February 2025 |
| Centre ID: | OSV-0003291 |
| Fieldwork ID: | MON-0045022 |

## About the designated centre

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

Cork City North 5 consists of three units all located within one large building in a city. Combined the three units can support a maximum of 27 residents. The centre mainly provides a full-time residential support for residents with intellectual disabilities of both genders and over the age of 45 but it also provides one respite place. Individual bedrooms are available for most residents but some twin rooms are in the centre. Other facilities available for residents include bathrooms, sitting rooms, dining rooms, kitchens and linen rooms. Support to residents is provided by the person in charge, nursing staff, care assistants and activation staff.

**The following information outlines some additional data on this centre.**

| | |
|---|---|
| Number of residents on the date of inspection: | 24 |

## 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 |
|---|---|---|---|
| Tuesday 11 February 2025 | 10:30hrs to 18:50hrs | Conor Dennehy | Lead |
| Tuesday 11 February 2025 | 10:30hrs to 18:50hrs | Niall Whelton | Support |
| Tuesday 11 February 2025 | 10:30hrs to 18:50hrs | Robert Hennessy | Support |

## What residents told us and what inspectors observed

Residents spoken with provided positive feedback. This included one resident speaking about the staff supporting them. The staff that were on duty on the day of inspection engaged with and supported residents in an appropriate manner. Attempts had been made to make the centre homely but issues with storage remained in the centre.

This designated centre was a single building that was comprised of three interconnected units. The centre provided mainly residential care including to those with high medical and mobility needs but there was one respite bed provided. On the day of inspection, 24 residents were present in the centre. During the inspection inspectors visited all three units but the majority of their time was spent in two of these units. As a result, inspectors met a number of residents and had an opportunity to speak with some of them. Some of the other residents in this centre did not communicate verbally while other residents were seen during this inspection but did not interact directly with inspectors.

Residents that did speak with inspectors generally provided positive feedback. An inspector met one such resident in their bedroom during an initial walkthrough of one of the units. This resident was in bed at the time but invited the inspector in before and saying that they were there because they were sick. The resident said though that they felt better at the time before telling the inspector that they had lived in the centre since 2011 and liked living there. The inspector asked if they had anything planned for the rest of the day with the resident responding that they would take it easy for the day. Activity records later reviewed for this resident indicated that watching television was the main activity they did in the centre with an inspector informed that this was what the resident chose to do.

Another resident was spoken with as they were in one of the unit's sitting rooms with three other residents as they watched television. This resident told an inspector that they had been swimming earlier in the day. They also indicated that they liked living in the centre. When asked by the inspector what they liked about living in the centre, the resident responded by talking about the staff supporting them. The resident said that they supported Manchester United and enjoyed rugby. This resident had an Irish rugby jersey on at the time and mentioned seeing a recent Irish ruby match. Positive comments were also made by the resident about the food provided and said that they would be having dinner later.

Later in the afternoon a third resident was met as they waited to be collected to attend an advocacy meeting away from the centre. An inspector asked the resident what these advocacy meetings were about and the resident said they talked about themselves at these. The resident went to speak about attending a Men's Shed and then told the inspector that they had recently gone to Rome with two staff members. The inspector was told by the resident that during this trip they had visited the Vatican and met the Pope. The resident said that they had enjoyed their

trip to Rome and it was noticeable that as they talked about this trip, the resident had a big smile on their face.

A different resident was also seen smiling as they mobilised around the unit where they lived while another resident in the same unit, raised a hand to greet an inspector but did not verbally interact with him. A third resident spoke with an inspector on two different occasions during the inspection day. During these discussions the resident asked the inspector about where the inspector lived and worked. When the inspector answered these, the resident talked about different towns in Ireland that they had visited. The resident also mentioned that they would be moving to a different setting soon which they wanted to do. The inspector was later informed that the resident was due to move away from the centre in the week following this inspection.

Throughout the inspection, staff members on duty and management present supported residents in an appropriate, caring and respectful manner. For example, twice during the inspection a resident was seen to become teary but on both occasions staff members present immediately reassured the resident which improved their form. Staff members were also seen to support residents with tasks and everyday activities such as bringing residents to have meals. It was noticeable that the general tone of discussions with staff and management was more positive and upbeat compared to some previous inspections of this centre. Such previous inspections had also raised issues around the general maintenance, cleanliness and storage facilities of the premises provided.

On the current inspection, this premises was seen, largely, to be presented in a clean, well-furnished and well-maintained manner although some bathroom vents were seen to require cleaning. Efforts had also been made to make the centre homely. For example, balloons to mark landmark birthdays for two residents were seen to be present in one unit. One of these residents was due to have a birthday party the day following this inspection with a sign about this on display in the hall area of one of the units. Most residents also had their own individual bedrooms. One bedroom was shared by two residents but it was indicated that both residents were happy with this. Another bedroom could be used for two residents but at the time of inspection, only one resident was residing there. An inspector was informed that there were no plans for a second resident to move in there.

For one resident, who had their own individual bedroom, the layout of the unit where the resident lived, meant that it was is possible to see into the resident's bedroom via windows from the unit's corridors. Care was needed to ensure that this did not impact the resident's privacy but it was seen that the windows in this resident's bedroom did have blinds which could be used to afford privacy if needed or if requested by the resident. Aside from this, the current inspection identified that storage issues remained in the centre. For example, in a control room some items were seen stored there which posed a fire safety risk given the presence of electrics in this room. Works to improve fire containment in one of the units were ongoing at the time of this inspection but during the course of this inspection significant

concerns were identified regarding fire safety. Such matters will be returned to later in this report.

In summary, while storage issues remained, the premises provided was generally well-presented on the day of inspection. Positive feedback was provided by residents with some residents seen smiling on the day. Evidence of good care and support was provided by staff and it was noticeable that such staff generally spoke in a positive tone compared to previous inspections.

The next two sections of the report 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 delivered.

## Capacity and capability

Some improvement was found during this inspection compared to previous inspections. However, based on a review conducted by the provider as part of a funding application, staffing and governance challenges remained. Similar issues had been identified by the provider previously and during past inspections of this centre going back to October 2022.

This centre had been inspected on behalf of the Chief Inspector of Social Services three times between October 2022 and October 2023 where a number of regulatory actions were identified in areas such as governance, staffing, personal plans and fire safety. The provider's compliance plan responses for Regulation 15 Staffing and Regulation 23 Governance and management for both the April 2023 and October 2023 inspections did not provide assurance to the Chief Inspector that the provider's stated actions would bring about compliance with these regulations. In November 2023 the provider was requested to submit a specific plan on how it come back into compliance with specific regulations that were judged non-compliant during the October 2023 inspection.

The provider submitted the requested plan which was similar in its overall content to the October 2023 compliance plan response but with time frames extended. Following receipt of this plan, the centre had its registration renewed until January 2027 with a restrictive condition attached on complying with this plan by 31 December 2026. The purpose of the current inspection was to assess the provider's progress with this plan. Overall, it was found that the provider had implemented the measures outlined in the November 2023 plan. This resulted in improved compliance in some areas, particularly relating to personal plans. Some improvement was identified also regarding staffing. However, a review conducted by the provider indicated that additional staffing was needed to support the running of the centre and the needs of residents.

It was also highlighted by the same review that there were governance challenges in the centre given the number of residents being supported. Such matters were well known to the provider with escalated risks around staffing and/or governance having been highlighted during the October 2022, April 2023 and October 2023 inspections. Such escalated risks remained active at the time of the current inspection and in the absence of additional resources being provided for this centre, it was unclear how the restrictive condition applied would be met. In addition to these, an urgent action was issued around fire safety during the current inspection. This was the third inspection since October 2022 where an urgent action in this area was issued for this centre. Given the nature of the fire safety concerns identified on the current inspection, further assurance relating to risk management were requested following the inspection. Such matters will be discussed further elsewhere in this report.

## Regulation 15: Staffing

At the time of all inspections of this centre between October 2022 and October 2023, an escalated risk relating to staffing in the centre had been identified by management of the centre. A business plan reviewed during the October 2023 inspection indicated that sufficient staffing was not in place to meet the assessed needs of residents. Following that inspection it was indicated that there was a requirement for a 50% increase in staff which was equal to 20 additional whole-time equivalent (WTE) staff. On the current inspection it was found that there was improvement around aspects of the staffing provided. For example, inspectors were informed that there were no staff vacancies in the centre while the provision of activation staff had increased (this latter point will be discussed further in the context of Regulation 13 General welfare and development). The escalated risk relating to staffing remained open at the time of this inspection although it was suggested that this was to be closed due to the absence of staff vacancies in the centre

However, since the October 2023 inspection a further review of staffing had been completed by the provider for the centre with the outcome of this reflected in a funding application for the centre dated February 2025. This highlighted that many residents needed 2:1 staff support for most activities of daily living and that staff were struggling to provide appropriate continuity of care and support. This application also referenced that there was an "urgent need" to increase staff in one unit due to changing needs. As a result, additional nursing staff, care assistants, social workers and multipurpose staff were being sought to support the operations of the centre. This application indicated that the centre had 40 WTE staffing in place but required 53.5 WTE. While it was acknowledged that the additional staffing required was now less than the 20 WTE previously mentioned, based on the outcome of the provider's review as reflected in the funding application, it was evident from this documentation the staffing arrangements were not in keeping with the assessed needs of residents.

Judgment: Not compliant

## Regulation 16: Training and staff development

The provider's statement of purpose for this centre dated November 2024 identified that the mandatory training requirements for all staff in this centre included:

- Safeguarding Vulnerable Persons at Risk of Abuse (to be done every three years)
- Manual handling (to be done every three years)
- Positive behaviour support training
- Infection Prevention and Control (IPC) training

However, based on a training matrix provided following this inspection, there were a number of training gaps identified. These were:

- Five staff who had not done safeguarding training and four staff who were overdue refresher training in this area.
- Nine staff who had not done manual handling training and seven staff who were overdue refresher training in this area.
- Thirty staff who had not done positive behaviour support training.
- Six staff who had not done IPC training and seventeen staff who were overdue refresher training in this area (based on the matrix provided such training was to be done every two years).

Based on such figures, staff working in this centre did not have access to appropriate training, including refresher training. Issues were also raised during this inspection about the provision of fire safety training which will be addressed in the context of Regulation 28 Fire precautions.

Judgment: Not compliant

## Regulation 23: Governance and management

The October 2023 inspection had highlighted that the registered provider had not ensured that the centre was adequately resourced or effectively monitored to ensure that the centre was consistent, safe and appropriate to residents' needs. During the current inspection the following monitoring systems were found to be in place based on records reviewed:

- A tracker was being maintained of actions from the October 2023 inspection. A copy of this tracker was provided during the inspection process which indicated that progress was being made with such actions.

- An audit schedule was in place for 2025. This set out specific audits to be done each month in areas such as rights restrictions, finances and clinical care. Audit records reviewed indicated that such audits were being carried out as scheduled in 2025.
- An annual review for the centre had been conducted which covered the period December 2023 to December 2024. A copy of this annual review was read by inspector and was found to assess the centre against national standards while also providing for feedback from residents and their representatives.
- Unannounced visits to the centre by representatives of the provider had been conducted on 2 March 2024 and 23 October 2024. Such visits were reflected in written reports and included action plans for addressing any issues identified in keeping with the requirements of this regulation. However, this regulation requires such visits to be conducted every 6 months and based on the dates on which the last two visits had been conducted, this requirement had not been met.

In addition to these monitoring systems, there was evidence that the provider had implemented the compliance plan actions since the October 2023 inspection. This resulted in improved compliance in some areas, such as personal plans and complaints, while it was noted that staff and management spoken with talked more positively compared to previous inspections. However, like such previous inspections, a number of regulatory actions were identified during the current inspection. This included noncompliances in Regulation 28 Fire precautions and Regulation 15 Staffing both of which had been found non-compliant in multiple previous inspections. Additionally, an inspector was informed that annual performance development reviews for most staff had not been completed in 2024. The additional staffing WTE highlighted as being needed for the centre to better meet the needs of residents, as referenced previously under Regulation 15 Staffing, also indicated that the designated centre was not appropriately resourced to ensure the effective delivery of care and support for residents.

The funding application for the centre dated February 2025 which highlighted the additional staffing WTE, also highlighted some issues with governance in the centre. The current centre was large in both its capacity and physical size. While a capable and knowledgeable person in charge was in place for the centre, who was supported by two clinical nurse managers and an area manager, the funding application highlighted that there was an urgent need to invest in the governance of the centre. In particular, it was highlighted that having one person in charge was "not sufficient" for the number of residents in the centre. Accordingly, the funding application contained a proposal for the centre to be split into three separate centres each with their own person in charge. Such a proposal had been mentioned during the October 2023 inspection but had not progressed since then. Consequently, an escalated risk related to the governance of this centre remained as had also been the case during the April 2023 and October 2023 inspections. From the finding of this inspection, previous inspections and the provider's own reviews it was not evidenced how the provider was going to ensure centre was appropriately resourced to meet the assessed needs of residents.

Judgment: Not compliant

## Regulation 3: Statement of purpose

A statement of purpose was in place for this centre. This is an important governance document that forms the basis of a condition of registration and which must contain specific information as required by the regulations. The statement of purpose provided as part of the inspection had last been reviewed in November 2024 and had most of the required information. This included details of the centre's organisational structure and the information in the centre's certificate of registration. However, staffing arrangements for the centre must be stated in WTE and the November 2024 statement of purpose only expressly indicated a staffing WTE of 31 which comprised of management, nursing staff and care assistants. This figure was noticeably lower than previous statements of purposes provided to the Chief Inspector and also less than the funding application for the centre as referenced under Regulation 15 Staffing. Other staff roles worked in the centre, including activation staff, but their exact WTE was not stated in the November 2024 statement of purpose. It was also noted that the description of one room in the statement of purpose did not reflect its actual use as observed on the day of inspection.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

Information about the complaints process was seen to be on display in the centre. Records of complaints in one unit were reviewed during this inspection. When reviewing these it was seen that they outlined the nature of the complaint and action taken in response. However, when reviewing such records on the day of inspection, it was not indicated if three complaints, relating to a similar matter, from December 2024 had been resolved or not. Such records also did not state if the complainants were satisfied with the outcome or not. This was highlighted to the person in charge and following the inspection, it was indicated that these complaints had been signed off and discussed with residents who were satisfied with the measures in place.

Judgment: Compliant

## Quality and safety

An urgent action was issued during this inspection relating to fire safety. A number of other fire safety issues were also identified which raised concerns around risk management. Notable improvement was identified relating to personal planning from previous inspections.

Under the regulations all residents should have an individualised personal plan in place that sets out their assessed health, personal and social needs. Such plans should also be reviewed on an annual basis or to reflect a change in circumstances. The three inspections of this centre between October 2022 and October 2023 had highlighted issues around such personal plans including some information being out-of-date or overdue a review. On the current inspection, noticeable improvement was found in this area which was a positive development. Such improvement was helped by the setting up of a group within the centre to oversee residents' personal plans.

Despite the improvement relating to personal plans, concerns were identified during this inspection relating to fire safety. Such concerns prompted an urgent action to be issued. The provider's response to this urgent action in the days following this inspection provided some assurance around the specific issues raised. However, a number of issues were identified regarding fire safety arrangements and the current inspection was the third inspection since October 2022 where an urgent action in this area had been issued. This raised concerns about risk management in this area which prompted further assurances to be sought from the provider around this in the days following inspection.

## Regulation 13: General welfare and development

The provision of activities for residents was highlighted as being a particular area of concern during the October 2022 and April 2023 inspections. Such inspection findings were influenced by staffing challenges particularly the assigned activation staffing WTE being lower than intended. This situation had improved by the time of the October 2023 inspection with additional activation staff in place at that time which resulted in more activities for residents. The same inspection did highlight though that there were some gaps in activity records for residents.

On the current inspection, it was again indicated that provision of activation staff had increased. This was a positive development. However, from rosters reviewed there could still be days when no activation staff would be present in the centre. This was evident from rosters reviewed while there was no activation staff present on the day of inspection. Other staff members spoken with indicated that supporting residents to engage in certain activities could be challenging if no activation staff were present in the centre. When reviewing activity records for residents on the current inspection, some gaps in these records was again noted. These included days where some residents were not recorded as having done or being offered any activity.

It was acknowledged though some residents in this centre had particular needs and preferences while other records reviewed did highlight some of the activities that

residents had done. For example, an inspector saw photographs of activities residents had participated in during January 2025 which included going to a concert and getting lunch out. In addition, when reviewing residents' personal plans, documents contained within these highlighted goals that residents had been supported to achieve during 2024 such as going to a musical, getting a mobile phone and setting up an email address.

Such goals were identified through a person-centred planning process although records reviewed did not always indicated if residents participated in planning meetings for this process. In addition, one resident had goals identified in January 2024 to visit certain relatives and to get sports television channels. It was not documented how or if these goals had been progressed. When queried, an inspector was informed that one of these goals had not been progressed and that the other should not have been identified as a goal for the resident.

Judgment: Substantially compliant

## Regulation 17: Premises

Given the size of the premises provided, it was generally observed to be well-presented on the day of inspection with attempts made to make the centre homelike. Most residents had their own individual bedrooms while communal space, such as sitting rooms and dining rooms, were provided. Multiple bathrooms in each of the three units that made up the centre were also provided for. While the centre was clean overall, it was observed that vents in some bathrooms required further cleaning. It was also seen that some blinds in a corridor leading towards the bedroom of one resident were hanging loose.

During the three inspections of this centre between October 2022 and October 2023, storage in the centre had been identified as an area in need of improvement. In response to the October 2023 inspection, it was indicated that storage solutions would be discussed. Based on observations during the current inspection, storage within the centre had improved somewhat with no wheelchairs seen to be stored in bathrooms unlike previous inspections. However, it was evident that storage continued to remain an area in need of improvement. For example, some discarded furniture was seen to be stored in a stairwell while items stored in a control room on the day of inspection posed a fire safety risk. Confirmation was received following the inspection that such items had been removed from the control room.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

The October 2023 inspection had identified that risk assessments and documentation relating to escalated risks for this centre had not been updated to reflect developments or were overdue a review. While such escalated risks remained active at the time of the current inspection, as discussed elsewhere in this report, documentation reviewed indicated that such risks were being monitored and reviewed. In addition, the October 2023 inspection found that some risk assessments relating to individual residents needed updating and/or review. Again on the current inspection, based on risk assessments reviewed for individual residents, such risk assessment had been reviewed in a timely manner. Aside from these risks, it was also highlighted during the October 2023 inspection that the risk related to fire safety had not been adequately considered or monitored.

On the current inspection documentation reviewed indicated that a risk had been escalated internally by the provider regarding certain fire containment works that were ongoing at the time of this inspection. However, a general risk assessment seen relating to fire safety as contained within the centre's overall risk register rated the risk of fire as low. As discussed further under Regulation 28 Fire precautions, a number of issues and hazards relating to fire safety were identified during this inspection. This included the issuing of an urgent action. This was the third inspection of this centre since October 2022 where an urgent action relating to fire safety had been issued for this centre. The issuing of urgent actions indicates high risks with the current inspection again raising concerns around the consideration and monitoring of fire safety risks in the centre.

Given the concerns found on the day of inspection, the Chief Inspector sought further assurances on risk assessment and assurance relating to fire safety in this centre. In response it was indicated by the provider that they had engaged an independent Fire Engineer, to carry out an audit of the centre. This audit was scheduled for 28 February 2025 and the provider committed to introducing an action plan to address any identified fire safety non-conformance issues.

The provider also committed to removing an older section of the premises provided from the footprint of the centre and highlighted the introduction of a new pathway for escalating risks. While such responses were noted, it remained a concern that some of the fire safety issues and hazards identified on the current inspection had not been identified sooner given the nature of the centre and previous inspection findings.

Judgment: Not compliant

## Regulation 28: Fire precautions

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk.

- the fire alarm/panel systems currently provided in the centre do not provide a means to identify where a fire started. This posed a significant risk as it could increase the time needed for staff support to arrive and assist in evacuating residents
- staff working in the centre have not received on-site practical fire safety training in a number of years

The provider's response did provide assurance that the risk was adequately addressed. A multi-disciplinary team met on site the day following the inspection to review the systems in place, including identifying fire alarm zones and devices and displaying this information on a floor plan. A fire safety training plan was also scheduled for roll out.

The provider had not ensured that effective fire safety management systems were in place;

- There was an ongoing programme of work to upgrade/replace fire rated door sets in the centre. Improvements were required regarding oversight of the construction work in the centre and the implementation of mitigating controls. The inspector observed two smoke detectors which were covered to prevent ingress of dust, however were not removed when the work was finished for the day. There was no system to monitor this, however the person in charge committed to monitoring this with a checklist moving forward
- fire doors in some areas were routinely left open, and would not close if the fire alarm was activated; for example the door between the kitchen and dining room. Others were propped open, even where a device was fitted to the door to release it when the fire alarm was activated
- residents evacuation requirements were assessed in the form of a personal emergency evacuation plan (PEEP).From a sample of PEEPs reviewed, there was no evidence to show that these were being reviewed every six months as per the provider's own statement of purpose. The person in charge confirmed this would be addressed immediately
- each unit in the centre had a separate fire safety register; from a sample reviewed, they were not being populated with all pertinent information. They included a record of the in house fire safety checks being carried out, however, these were not all being completed in line with the providers own intended frequency. While daily checks of the means of escape were logged, the weekly test of the fire alarm system was not.

Action was required to ensure adequate precautions against, and protect residents from, the risk of fire, for example:

- The process for the identification and management of fire safety risks was not adequate, for example; the arrangements for the storage of oxygen cylinders required review
- There was a large oxygen cylinder in a store room, with an expiry date in excess of 14 months. It was also inappropriately stored in a room with combustible storage, increasing the risk if a fire started

- combustible storage was inappropriately stored within electrical rooms
- there was evidence that people were smoking in areas, which were not dedicated smoking areas; these areas were not suitable and not fitted with appropriate fire safety equipment or receptacle to discard cigarette ends
- the position of some sockets adjacent to a resident's bedding on their bed required review; the inspector observed bedding up against electrical sockets

The arrangements for providing adequate means of escape including emergency lighting were not adequate;

- the provision of exit signage required review; for example, the exit door near the family room did not have an exit sign and in some corridors, the exit signage was not visible to highlight the route of escape
- the provision of emergency lighting along external escape routes was not adequate to safely guide occupants from the exits to a place of safety if the power in the building failed
- where new exit doors were installed, there was no emergency lighting outside the door. One of these exits had a drop of approximately 50mm, creating a difficulty for manoeuvring wheelchairs or beds through the exit door
- there was inappropriate storage in the open hall containing the stairs at lower ground floor (trollies, old furniture and boxes of supplies), which was an escape route. This area had a weighing machine which was left plugged in; this required risk assessment to determine if its location was suitable.

There were ongoing works in the centre to improve fire containment; this consisted primarily of a programme of upgrade or replacement of fire rated door sets. When complete this, this will require sign off by the competent person and would greatly improve fire containment. Notwithstanding these improvements the measures in place to contain fire in the fabric of the building was not adequate and required action;

- assurance was required regarding the integrity of fire containment, in particular fire compartment boundaries in the building, to ensure the safety of residents during evacuation
- there were service penetrations through fire resisting construction which were not adequately sealed up, for example, holes in ceiling of the electrical room and the food store
- ceilings throughout had attic hatches, ventilation openings and recessed lights which compromised the fire containment of the ceilings
- fire doors to bedrooms consisted of a small and larger leaf. While the larger leaf had a door closer, the small leaf did not. This presented a risk of the small door leaf being left open during evacuation; staff did not include the procedure to close and re-latch the door as part of the bed evacuation strategy

The arrangements for detecting fire and giving warning of fire required action;

- There were three separate fire detection and alarm systems in the building, two of which were interconnected. The system in the convent section

included a light beacon and sounder beside the main fire alarm panel. On activation of this sounder, staff would be required to go to another panel in the convent area and search that part of the building to locate the fire. The other two panels identified the zone and number of the device activated; there was no zone floor plan or schedule displayed to assist in identifying the location of an activated device. Staff did not know what was displayed and were unsure of where zones were located
- there was a smoke detector up against a duct, and didn't have an appropriate clear space around it to ensure it was effective
- a store room under the stairs in in one unit and the medical store in another unit did not have smoke detection

The arrangements for maintaining fire equipment, means of escape, building fabric and building services were not effective:

- the records for the servicing of the emergency lighting and fire detection and alarm system, were not available for review
- there was no record of the periodic inspection for the electrical installation in the building
- other than the fire doors subject to replacement or upgrade, there were maintenance deficits to some fire doors such as, screws missing to hinges, gaps around fire doors and some heat and smoke seals missing and an automatic door closer had been disconnected

The measures in place to safely evacuate residents and the drill practices in the centre required action:

- The narrative in the provider's PEEP's included an alternative if deemed necessary; that the bedroom door was a fire door and the resident can be left in the bedroom until the emergency services arrive. There was no rationale provided on the day in relation to this alternative, which did not provide assurance in the event of evacuation.
- drill records reviewed included a predetermined safe evacuation time and the actual simulated evacuation time, which was good practice, the detail in the drill records did not include pertinent information such as the evacuation aids used, where evacuated to and who participated

The provider had not made adequate arrangements for staff in the centre to receive appropriate training in fire safety; the fire safety training was an online module and was not centre specific. Staff spoken with confirmed that they had not received training in all aspects of the requirements of the regulations, for example, staff had not received training in fire control techniques such as extinguisher training

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

A sample of personal plans were reviewed during this inspection. These were found to contain guidance on how to support the assessed needs of residents. Such guidance was found to have been reviewed within the previous 12 months and been informed by relevant assessments which had also been completed within the previous 12 months. This helped to ensure that residents' personal plans contained up-to-date information and this was a notable improvement from previous inspections. It was indicated that the improvement in this area had been influenced by an internal group within the centre that had been set up to oversee residents' personal plans.

Aside from personal plans, the October 2023 inspection highlighted that the living environment for one resident was not suited to their needs which had the potential to impact other residents. On the current inspection, inspectors were informed that this remained the case and that unsuccessful attempts had been made to find a more suitable setting for the resident and to offer additional supports to the resident. Two inspectors briefly visited the unit where this resident lived during the inspector and the resident was heard to regularly vocalise during this period. It was highlighted though that this resident's presentation had improved in recent months while a change in circumstances in the unit where the resident lived had also improved matters.

Judgment: Substantially compliant

## Regulation 8: Protection

Since the October 2023 inspection, some notifications of a safeguarding nature had been submitted to Chief Inspector from this centre. Documentation reviewed during this inspection indicated that such matters had been appropriately screened with safeguarding plans put in place where necessary. Staff members spoken with also demonstrated a good awareness of active safeguarding plans in the centre. A training matrix provided indicated that most staff had completed relevant safeguarding training but some gaps in this area were identified. These are addressed under Regulation 16 Training and staff development.

Judgment: Compliant

## Regulation 9: Residents' rights

Staff members during this inspections were observed and overheard to interact with residents in a respectful manner. There were also indications that residents' choice was promoted. Notably, one resident told an inspector that they would be moving elsewhere which they wanted to do. The same inspector was informed by

management that this was something which the resident had expressed a wish to do in order to live closer to their family home with the resident supported to pursue this. During the inspection, it was highlighted that the resident would be moving away from this centre in the week following this inspection. Documentation reviewed relating to another resident highlighted that a referral had been made for the resident to obtain an independent advocate with the resident remaining on a waiting list for one at the time of this inspection.

Notes of resident forum meetings were reviewed by an inspector in one unit of the centre which were undertaken on a monthly basis. Areas covered in these meetings included shopping, activities, fire safety, safeguarding, complaints and finances. However, it was not clear from the meeting notes how the residents contributed to the meetings as many of the meeting notes were similar in nature. The content of such forum meetings had been raised during the October 2023 inspection as an area for improvement. In addition, during the current inspection it was observed that some documents with personal information relating to residents was stored in an unsecured manner in one room. This had the potential to adversely impact residents' privacy. Given that it was possible to see into one resident's bedroom from the corridors of one unit, care was also needed to ensure that this layout did not impact the privacy of the resident.

Judgment: Substantially 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 | Not compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Substantially compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Cork City North 5 OSV-0003291

## Inspection ID: MON-0045022

## Date of inspection: 11/02/2025

**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 | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>The provider has received confirmation of funding for the increase in staffing and management which will allow the provider to divide the centre into three separate designated centres. The additional funding will equate to a 13.5 uplift in staffing.<br>The date the register provider will be in compliance with Regulation 15 is the 31/12/2026<br>The provider will develop a project management plan to implement the new structure within the designated centre which will include the registration of the new designated centres and recruitment of staff and a further 2 PICS. As outlined in the previous compliance plan from the Inspection in October 2023, staffing arrangements to meet the assessed needs of residents will be completed 31/12/2026. | |
| Regulation 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>All staff have completed their Safeguarding Vulnerable Adults Training. (31/03/2025)<br><br>Of the 16 staff who were due manual handling training, 6 staff have completed training as of 18/02/2025. 2 further staff will be completing Manual Handling training on the 08/04/2025 and the remaining 6 staff are currently on a waiting list. Once dates become available, staff will be booked to complete this training. 31/10/2025<br><br>All staff who require Positive Behaviour Support training have been scheduled to complete training by 31/10/2025, with the additional dates given by the department to | |

facilitate this.

All staff who were due IPC training completed 31/03/2025. Staff who are due refresher training will have this completed by 30/04/2025.

All staff have completed fire training 14/03/2025.

The designated centre has a training matrix in place. There is a staff delegated to monitor the matrix to ensure that all staff training is in date. Any staff that is due to complete online training is notified. For any face to face training requirements, the delegated staff member notifies management of training that is due within the following 3 months. Management then book the training required as appropriate. The delegated staff informs management of any issues in training being completed at the time. The PIC reviews the training matrix quarterly or sooner as required.

| | |
|---|---|
| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider acknowledges that two six-monthly unannounced visits were completed within the year; however, they fell just outside the required timeframe. This was due to a change in personnel responsible for conducting these visits. To address this, the provider has appointed an interim person to the role. Since their appointment, all six-monthly unannounced visits have been completed within the required timeframe. Additionally, a six-monthly tracker has been implemented to ensure ongoing compliance with Regulation 23 by monitoring and scheduling visits within the appropriate timeframes. Furthermore, the provider has revised the six-monthly report form to include an action plan. This ensures that any issues or concerns identified during the visit are documented, with clear actions assigned to address them in a timely manner. This enhancement strengthens governance and oversight, ensuring continuous improvement within the designated centre.

Performance Management Reviews for all staff will be completed by management on 31/12/2025.

The provider has received confirmation of funding for the increase in staffing and management which will allow the provider to divide the centre into three separate designated centres. The provider will develop a project management plan to implement the new structure within the designated centre which will include the registration of the new designated centres and recruitment of staff and a further 2 PICS. As outlined in the previous compliance plan from the Inspection in October 2023, the designated centre will be appropriately resourced to ensure the effective delivery of care and support for residents by 31/12/2026.

| | |
|---|---|
| Regulation 3: Statement of purpose | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Although WTE of specified grades amounts to 31 on the staffing figure box, the remaining overall WTE (9) for the designated centre is utilised through relief/activation and housekeeping as stated below the box on page 10.

However, the provider acknowledges that this needs to be displayed more clearly in the SOP clearer and is currently reviewing this. An updated SOP that clearly accounts for all grades of staff in line with the funded number will be in place in the designated centre. 31/05/2025

A review of the floor plans is scheduled and required changes will be implemented 31/05/2025/.

| | |
|---|---|
| Regulation 13: General welfare and development | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
There are four activation staff employed to CCN5 and they work over a 7-day week. The only time there is not an activation staff present is to facilitate pre planned leave / sick leave. On the occasional day that there is no activation staff rostered, the staff on the floor provide meaningful activities to the residents. At the time of inspection, the designated centre had no vacancies.

All PCP documentation indicates those present during the Person-Centred Planning meetings including the people we support. All residents participated during their PCP meeting with their key workers. However, to ensure that staff can demonstrate more clearly the voice of the person throughout this document, all staff will receive PCP training 30/06/2025.

The activation staff review PCP goals for each resident monthly. The Activation staff develop a schedule for each resident to ensure that all residents within the designated centre are achieving their goals as per their will and preference.

All staff have been met by PIC to discuss the importance of consistently completing all

documentation, including activation records, choices offered and any changes to resident's preferences around goals 18/02/2025. This is an ongoing topic item on staff meeting agendas.

| Regulation 17: Premises | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 17: Premises:
Deep cleaning of all the bathrooms will be completed by 30/04/2025. Maintenance on the blinds has been completed. 31/03/2025. The requirement for additional storage has been reviewed and costings submitted. The additional storage will be completed by 31/08/2025

| Regulation 26: Risk management procedures | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk related to fire was rated as per HSE risk rating. The likelihood of fire was rated 1 as a fire has never occurred in the designated centre and Impact at the highest being 5. The risk of fire remains low despite the issues identified during the inspection. In addition, the risk was escalated, accepted and signed by the PPIM with the additional controls being implemented at the time of inspection, nearing completion. There was evidence that the risk was reviewed by the PIC and remained open with additional controls in place. There is an updated risk assessment in place while works progress on the installation of new fire doors completed on the 14/02/2025.

The provider will submit an application to vary to remove the old convent section of CCN5 once the resident who lives there has moved and settled into their new home and the HSE approves the suppression of this vacant bed 30/06/2025.

The provider has introduced a new Integrative Risk framework which includes an 'Escalated Risks Pathway", where PICs can escalate concerns/risks beyond their control, to the Regional Managers (PPIM). This process is monitored by the Quality and Safety Advisor, the Health and Safety Officer and overseen by the Chief Operations Officer (COO) on behalf of the provider. PPIM can escalate risk to the COO if concern/risk is beyond their control. Risk trends are presented to the providers executive team on a regular basis.

The Providers Integrative Risk Framework and risk management policy in parallel with the providers Reg. 23 audits, the designated centres quality, health and safety audits and fire audits, local documentation in the designated centres fire book and risk register, fire drills, fire alarm checks, fire panel and extinguisher checks and maintenance as needed as well as staff receiving fire safety training and fire warden training and a recent independent fire philosophy review of the designated centre offers assurances that risk relating to fire safety are assessed, managed and reviewed on an ongoing basis.

**The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations**

| | |
|---|---|
| Regulation 28: Fire precautions | Not Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Health and Safety Officer, The Facilities Manager (BSc MEng), The Lead Electrician and the appointed provider Architect (RIAI) visited the designated centre on the morning of the 12/02/2025 to review to the current systems in place. Following this review, the following actions were completed- Location of All Fire Alarm devices (Manual Call Points, Detector Heads, Fire Panels) marked up, identified and verified back to panel on existing floorplans by the lead electrician and verified a 2nd time by the facilities manager. The architect has created an official floor plan detailing all Fire Alarm Devices and location of same. These plans have been erected next to each fire panel so that location of the fire can be identified from the panel. Training has been provided to staff on Fire Panel interrogation and cross reference with Fire Alarm Floorplans for ease of identification of source of activation.

Staff have received online fire training provided by the Learning Rooms which covers the principals of fire safety and prevention including identifying the main causes of fire in the workplace, classify the types of fire. Identify the types of fire extinguisher and choose the correct fire extinguisher for each fire type. Carry out the correct procedure on discovering a fire. Outline practices for fire prevention and follow the correct evacuation procedures.

Staff whose training requires updating have been sent the link for this and this has been completed 23/02/2025.

All staff have read The Providers Fire Safety Policy and Guidance, evidence of this is maintained within the designated centre. In addition, all staff are aware of residents PEEPS within the centre.

The registered providers contractors provided staff training on the fire panel including zoning maps 14/02/2025

Advanced onsite Fire Warden training has been completed by 20 staff to date.
This course covers:

1. Fire Awareness
o Hazards
o Fire Spread and Compartmentation
o Smoke, Gas and Carbon Monoxide
o General Fire alarm procedures
o Use of Evacuation equipment
o Fire Triangle / Causes of Fire, Fire prevention theory
o Fire prevention, containment
o Fire Zones / Compartments and Fire Doors
2. Evacuation Procedures – PEEPS review and practice
o Fire Alarm Panel – use and zones
o Evacuation procedures for Riverview 1, 2 and 3.
o Resident accommodation – Risk review and PEEP's discussion
o Demonstration and use of evacuation aides
o Simulation of Evacuation (Complex needs / PEEPS led)
3. Fire Fighting
o Practical use of extinguishers
o Types of extinguishers

There will be a designated fire warden assigned to each shift who has completed the above training.

There is an updated risk assessment in place while works progress on the installation of new fire doors completed on the 14th February.

A checklist is completed daily prior to the maintenance team leaving the centre to ensure that equipment is stored in appropriate areas and there is no obstruction to fire detection systems.

A local protocol is in place for the use of the kitten doors within the designated centre to ensure appropriate usage in line with fire safety guidelines 31/03/2025. The PIC has discussed with all staff the importance of ensuring that fire doors are not propped open as this prevents them working in the intended way to prevent the spread of fire 12/02/2025. This is an ongoing agenda item at staff meetings.

There is a PEEPS completed for all residents and all staff are aware of residents PEEPS within the centre. There is a schedule in place to review PEEPS three monthly or sooner if the residents need change. In addition, management will review all PEEPS in line with personal plan audit schedule.

Fire Wardens will be allocated on each shift and they can provide in house training and support to staff locally. The fire wardens are responsible for completing daily and weekly fire safety checks and this is reviewed by management monthly. Any deficits found during these checks will be escalated to management at the time.

The Health and Safety Officer, will collaborate with the Regional Manager, with responsibility for CCN5, to ensure the Person in Charge, has additional supports as required, for the development of local risk assessments and the identification of escalated risks. The Health and Safety Office and Facilities Manager have reviewed the

current general emergency evacuation plan. Following this review an updated General Emergency Evacuation Plan (GEEP) has been developed and issued to the designated centre. Staff have been provided training and guidance on this updated plan 14/02/2025. The PIC will ensure the GEEP is reviewed at least annually by the PIC, Health and Safety Officer and Facilities Manager or sooner if required. The PIC reviews the local onsite risk assessment 6 monthly or sooner if required.

The out of date oxygen cylinder has been removed from the centre 12/02/2025. All staff are aware of the appropriate storage of oxygen.
Combustible storage has been cleared from all electrical rooms 12/02/2025

All staff have been made aware of designated smoking areas for the centre which have the appropriate fire safety receptacles to dispose of cigarette ends 12/02/2025

Staff have been made aware that bedding should not be up against electrical sockets and appropriate changes to positions of beds/bedding has been made 12/02/2025

Maintenance on exit signage, emergency lighting and holes in the ceilings in some store rooms has commenced and all works will be complete by 31/05/2025.

The 50mm drop on the exit has been levelled for ease of manoeuvring wheelchairs and beds through the door 31/03/2025.

The storage in the open hall has been removed and appropriate space for egress in the event of a fire is maintained 12/02/2025.

The Provider has engaged an independent Fire Engineer, to carry out an audit of the property as outlined in the 2022 Approved Code of Practice, Fire Safety in Buildings and Premises 28/02/2025. The Facilites Manager will set out an action plan to address all identified fire safety non-comformance issues, from the Fire Engineers report 30/06/2025.

It is not recommneded for the smaller leaf to be self closing as this may inhibit safe & timely egress particulaly in the scenario of bed evacuation. A local protocol is in place for the use of the kitten doors within the designated centre to ensure appropriate usage in line with fire safety guidelines 31/03/2025. The Intumescent seal Interruptions at the Hinges, Locks & Flush Bolts fall within the Testing & Certification tolerances for the Fire Doors recently installed in CCN5.

Smoke detector next to the duct now has clear space around it to ensure it can work effectively 31/03/2025

There are smoke detectors in all areas required 31/03/2025

The providers nominated contractor completes annual Fire & Safety Checks for fire safety equipment and complete quarterly checks for the emergency lighting and fire alarm system. Reports following these assessments will be kept on site 31/03/2025

The electrical contractor for Horizons, will carry out a Periodic Inspection Report (PIR) on

the electrical installation of the building will be completed by 31/03/2025. A certificate will be issued following this.

Works have commenced to address the maintenance deficits to some doors. These works will be completed 30/06/2025
All PEEPS have been reviewed and statement that a resident can be left in their bedroom until emergency services arrive has been removed 14/02/2025. There is a schedule in place to review PEEPS three monthly or sooner if the residents need change. In addition, management will review all PEEPS in line with personal plan audit schedule.

Monthly day and night fire drills are taking place in the designated centre. Records of these include all appropriate information as per onsite Fire Warden training. Management review documentation relating to fire drills monthly 31/03/2025.

| | |
|---|---|
| Regulation 5: Individual assessment and personal plan | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC and PPIM continue to explore all available options for a more suitable environment for this resident. However, with the change in current environment, there are improvements noted in the resident's presentation there has been no NIMs, Notifications or Complaints in relation to this resident as the person accused of causing concern in a 7-month period. Resident was reviewed by psychiatry 02/04/2025 and noted improvements have also been documented. Resident also enjoyed a recent holiday with peers and staff. Whilst it was noted on the day of inspection that the resident was vocalising this is the resident's typical presentation and does not appear to be negatively impacting the other residents.

| | |
|---|---|
| Regulation 9: Residents' rights | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Residents forums will be allocated to two staff per shift to ensure completion and residents views are captured documented appropriately 30/04/2025. Management will review residents' forums monthly.

Documents relating to personal information was sent for confidential shredding / filing and is no longer stored in the designated centre 12/02/2025

The residents room has blinds and these are always closed when personal care is being carried out. When the resident is spending time in their bedroom, staff open and close the blinds as per their will and preference on the day.

## 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 13(2)(b) | The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs. | Substantially Compliant | Yellow | 30/06/2025 |
| 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. | Not Compliant | Orange | 31/12/2026 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to | Not Compliant | Orange | 31/10/2025 |

| | | | | |
|---|---|---|---|---|
| | appropriate training, including refresher training, as part of a continuous professional development programme. | | | |
| Regulation 17(1)(c) | The registered provider shall ensure the premises of the designated centre are clean and suitably decorated. | Substantially Compliant | Yellow | 31/08/2025 |
| Regulation 17(7) | The registered provider shall make provision for the matters set out in Schedule 6. | Substantially Compliant | Yellow | 31/08/2025 |
| Regulation 23(1)(a) | The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. | Not Compliant | Orange | 31/12/2026 |
| 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 | Substantially Compliant | Yellow | 31/12/2025 |

| | | | | |
|---|---|---|---|---|
| | 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. | | | |
| 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 responsibility for the quality and safety of the services that they are delivering. | Not Compliant | Orange | 31/12/2025 |
| Regulation 26(2) | The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. | Not Compliant | Orange | 30/06/2025 |
| Regulation 28(1) | The registered provider shall ensure that effective fire safety management systems are in place. | Not Compliant | Orange | 31/08/2025 |

| | | | | |
|---|---|---|---|---|
| Regulation 28(2)(a) | The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings. | Not Compliant | Orange | 31/08/2025 |
| Regulation 28(2)(b)(i) | The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services. | Not Compliant | Orange | 31/08/2025 |
| Regulation 28(2)(b)(ii) | The registered provider shall make adequate arrangements for reviewing fire precautions. | Not Compliant | Orange | 31/08/2025 |
| Regulation 28(2)(c) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | 31/08/2025 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/08/2025 |
| Regulation 28(3)(b) | The registered provider shall make adequate arrangements for | Not Compliant | Orange | 31/08/2025 |

| | | | | |
|---|---|---|---|---|
| | giving warning of fires. | | | |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Substantially Compliant | Yellow | 31/08/2025 |
| Regulation 28(4)(a) | The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents. | Not Compliant | Orange | 31/08/2025 |
| Regulation 28(4)(b) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Substantially Compliant | Yellow | 31/08/2025 |

| | | | | |
|---|---|---|---|---|
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 31/05/2025 |
| Regulation 05(2) | The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1). | Substantially Compliant | Yellow | 02/04/2025 |
| Regulation 09(2)(e) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre. | Substantially Compliant | Yellow | 31/05/2025 |
| 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 | Substantially Compliant | Yellow | 31/05/2025 |

| | | | | |
|---|---|---|---|---|
| | personal information. | | | |