Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City South 3
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	30 May 2022
Centre ID:	OSV-0003311
Fieldwork ID:	MON-0031634

About the designated centre

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

The service is for adults with an intellectual, physical disability and/or autism who require residential care. The centre is comprised of three detached buildings located beside each other in a housing estate. The centre is located close to the city with transport available. One of the buildings is a single storey building divided into two houses with an interconnecting keypad door which residents had the access code for. The remaining two buildings are two storeys and all three buildings are of a similar design and layout. Each of the buildings consist of two kitchens with adjoining dining and sitting areas and two smaller sitting rooms which could be used for visitors. Combined, the three buildings consists of 31 separate bedrooms for residents while staff facilities such as staff offices were also available. The centre is open and staffed on a full-time basis. The staff team is comprised of nursing and care assistant staff led by the person in charge and a clinical nurse manager 1(CNM1).

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	30

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 30 May 2022	08:55hrs to 19:30hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

Findings on the day of this inspection indicated that significant improvements were required to ensure effective governance and oversight arrangements were in place in the centre and that the service provided was safe and appropriate to residents' needs.

This was an unannounced inspection. On arrival the inspector met with one staff member who brought them to an office in one of the houses. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector adhered to these throughout the inspection. The person in charge arrived shortly afterwards and was available to the inspector throughout the inspection. The person in charge and the person participating in management attended a feedback meeting held via video conference the following day. Two urgent actions were issued at the feedback meeting. These required the provider to confirm what actions they had taken, or proposed to take, to address significant non-compliances identified within a time specified by the Chief Inspector. One action related to the governance and management arrangements in the centre, the other to staff training, medication management training in particular. A provider assurance report was also requested. These will be described in more detail in the next two sections of this report.

The centre is located on the outskirts of Cork City in a residential area and is part of a purpose built complex developed by the provider. In addition to this designated centre, a number of apartments are also located within the complex. The designated centre is comprised of three buildings, made up of six semi-detached residences. In practice, these are run as three separate houses. Eight residents live in one single-storey house, 12 in an adjacent two-storey house, and 11 in another adjacent two-storey house.

The centre was registered to accommodate 31 adults. A range of services were provided in the designated centre. On the day of inspection a full-time residential service was available in 28 bedrooms, a respite service was provided in two bedrooms and a shared care service was provided in one bedroom. It was noted that these services were different to those outlined in the statement of purpose that had been submitted when the centre's registration was last renewed in January 2021. On the day of this inspection there were 30 residents staying in the centre. The inspector had the opportunity to spend time with 20 of these residents.

Residents living in the designated centre had a wide range of interests, abilities and health and other support needs. Residents' ages ranged from 37 to 73 years old. 22 of the residents were aged 51 or older, with four of these in their 70s.Given the age profile, the overall needs of the resident group in the centre were increasing. Two residents had been diagnosed with dementia and another had been referred for assessment. A number of residents' mobility needs were increasing, falls were occurring more regularly and some residents now used mobility aids to help them

move throughout the centre and when outside. The person in charge told the inspector that residents living in the single-storey house required support with all activities of daily living while the other 23 residents were described as semi-independent. When asked if any of the residents left the centre independently, the person in charge advised that support from staff or a relative was required to facilitate this. They went on to explain that two residents participated in a weekly arts course independently, however support was required to bring them to and from the class.

On arrival, the inspector spent some time in the single-storey house. The house was well furnished. Items on display included televisions, arts and crafts and other activities, and equipment used to aid transfers. There was a small sitting room in both sides of this house. There was limited space available in these rooms as they were used to dry clothes and also to store large chairs that had been prescribed for specific residents. Staff informed the inspector that a number of these were no longer in use. There was a large open plan kitchen, dining and living area in both sides of the house. Although these were well equipped and were accessible to residents, they were observed to be in need of repair and cleaning. For example, kitchen units were damaged, floors and other surfaces were unclean, and blinds and other fittings were in need of replacement or repair.

The inspector spent some time with two residents while in this house. At that time their peers were either still in bed or were getting ready for the day. Support was provided by one staff and it was observed to be respectful and unhurried. One resident followed the inspector into the smaller sitting room and staff advised that they liked to spend time there. Later this resident and a peer were in the dining area. One resident was engaging in a preferred activity at the table. Neither resident communicated verbally with the inspector but both appeared at ease in each other's and staff's company. When in this area, the inspector noticed a poster with photographs outlining the staff working there that day. This was not accurate.

The inspector then moved to the two two-storey buildings, where they spent the remainder of the inspection. These houses had a similar ground floor layout to the first house visited. Slight differences included the use of one of the smaller living rooms as an art room in one house, and as a staff office in the other. The art room was well equipped. One resident who lived in this house was especially interested in art. Again these houses were well furnished and a variety of activities of interest to the residents were available. These houses were observed to be cleaner than the first, however also had areas where maintenance and upkeep were required. Some walls were marked due to the behaviour of one resident, fabric on furniture was worn or torn, some blinds required repair or replacement, and kitchen units were damaged. It was also noted that the Certificate of Registration, issued by HIQA (Health Information and Quality Authority), on display was out of date. The inspector viewed a selection of residents' bedrooms and found that they were clean and had been personalised and decorated in line with residents' tastes and interests.

The two residents accessing a respite service in the centre lived in one of the larger houses. The inspector was informed that both had been living in the centre on a full-time basis since March and November 2021 respectively. The inspector met with

both of these residents. One had been asked to temporarily move to another house within the designated centre so that another resident could live in a house with waking night staff due to a healthcare need. This resident said they were happy to help the other person and liked staying in both houses. The other resident reported to being content staying in the house and the services provided.

The inspector also spent time with 15 other residents living in these houses. One resident spoke to the inspector about going to a local supermarket the previous day with some peers and a staff member. They told the inspector that they enjoyed shopping and had not been in a supermarket 'in years'. Following this inspection, management advised that this resident is occasionally supported to attend a supermarket by family members or while attending their day service. Another resident spoke with the inspector about a relative who brought them out regularly. One resident spoke excitedly with the inspector about a course they would be beginning shortly in a local university. This resident was proud that they, like their siblings and cousins, would be graduating from university. Another spoke with the inspector about a musical instrument they played, performances they had given and how they wanted a music teacher so that they could learn more. This resident also spoke about upcoming family occasions and showed the inspector a photograph of a dress they had bought to wear.

Some residents were observed participating in everyday tasks such as eating a meal, having a cup of tea, contacting a relative on their mobile phone, clearing the table, bringing clothes to the laundry, knitting and chatting with staff. Other residents were not observed to be engaged in any meaningful activities. For example in one house, six people were seated around a television but only one appeared to be watching it. When speaking with one of these residents they told the inspector that they did not like watching television and instead preferred listening to music or sports commentary. They then told the inspector that they enjoyed playing golf and doing yoga and asked if they knew when or if these activities would return. Not all residents wished to speak with the inspector and this was respected.

Most residents living in the single storey house were supported to participate in daytime activities by residential staff. Only one of these eight residents attended a day service. In the larger houses, the majority did attend a day service from Monday to Friday. Three residents had chosen not to attend day services and instead they spent this time in the larger house that was staffed by day. The staffing levels varied in each house. As will be outlined later in this report, and had been highlighted following previous HIQA inspections, findings on the day of this inspection indicated that the staffing levels in the two houses that could accommodate 11 or more residents were insufficient.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the three most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. The inspector asked to see a staff training matrix so as to assess if staff were up to date with mandatory training. An up–to-date version was

not available. This will be discussed further in the next section of this report. The inspector reviewed the documented incidents that occurred in the centre in 2022. As well as identifying incidents that had not been reported to HIQA, as is required by the regulations, this review also prompted the issuing of a provider assurance report. This will be discussed further in the 'Quality and safety' section. The centre's risk register was reviewed and while recently revised, further revision was necessary to ensure that all hazards in the centre had been risk assessed and the risk assessments were accurate and reflective of the centre. The inspector also looked at a sample of residents' personal plans. These included residents' personal development plans, healthcare and other support plans. Significant gaps and areas for improvement were identified. These findings will also be described in more detail in the remainder of this report.

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 to each resident living in the centre.

Capacity and capability

Improved governance arrangements and additional resources were required to ensure that a high quality, safe service was provided to residents in this centre.

The person in charge informed the inspector that they had sought additional management support the week before this inspection and had highlighted their concerns regarding the staffing, governance, and changing needs of the residents in the centre. As a result, weekly meetings with the person participating in management had been scheduled. The person in charge advised that it had also been approved for some staff to work overtime hours to support management in addressing identified areas requiring improvement. The person in charge also advised that they had requested a staffing allocations meeting to review the staffing arrangements in the centre.

There was a clearly defined management structure in the centre which identified the lines of authority and accountability. Staff reported to the person in charge who in turn reported to the person participating in management, who reported to the chief operations officer.The person in charge had been in the role for four months at the time of this inspection. Prior to that they had been a member of the management team in the centre since May 2020. Since their appointment, their former role remained vacant. A senior manager confirmed to the inspector that recruitment was underway and the position had been advertised.

As mentioned in the opening section, there were a number of apartments located on the same campus that were not included in the designated centre. When asked if those managing this centre had any management responsibilities for the apartments or those living in them, the inspector was informed that this was 'a grey area'.

Although the centre's statement of purpose outlined that the person in charge was one full-time equivalent position for this centre, if it was evident that they also fulfilled some responsibilities for the residents living in the apartments. Clarity was required regarding these arrangements.

An annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as is required by the regulations. However, the annual review did not include consultation with residents or their representatives, which is also required by the regulations. It was noted that on some occasions although issues were identified in monitoring reports, these were not always reflected in the judgment given. For example, in July 2020 it was identified that not all staff had the required up-to-date mandatory training. Despite this, the regulation regarding training and staff development was assessed as compliant. This has also been a finding in other designated centres operated by this provider.

When reviewing these documents it was noted that a number of actions outlined in the November 2021 annual review were repeated in the March 2022 six-monthly visit report. The provider's representatives had assessed the centre as not compliant with the regulations regarding governance and management, risk management and residents' rights on both occasions. In three of the four reports reviewed there were no documented action plans, persons responsible or time frames to address these identified non-compliances. Although they were not seen by the inspector on the day, following this inspection management advised that action plans were available in the centre. Not all agreed actions on these plans had been completed within the stated timelines. A number of other areas requiring improvement, including residents' personal plans, staff training, and the staffing levels and skill mix in the centre had been also identified in these internal reports. These were identified again during this inspection. These findings indicated that even when the provider had identified areas requiring significant improvement they had not acted to address them.

As outlined in the opening section of this report, different staffing levels were provided in each house in the centre. The house that could accommodate eight residents had six staff working from 8:00 to 20:00 every day. By night, there were three staff who remained awake. The house that accommodated 12 residents had two staff by day (8:00 to 20:00) and one staff who remained awake by night. The house that accommodated 11 residents was not staffed during the day. One staff member worked from 16:15 until 22:00. That staff member then slept in the centre working again the following morning from 7:00 to 10:00. Additional support was provided by one staff member from 8:00 to 9:00 and by another from 17:00 to 21:30, from Monday to Friday. At the weekends two staff worked in the house from 10:00 to 20:00, with one completing a sleepover shift.

This planned roster meant that at best two staff supported 11 or 12 residents in two of the three houses in this centre. Findings on the day of this inspection indicated that this was not sufficient to meet these residents' assessed needs. Residents living in these two houses had a variety of assessed needs, including healthcare needs (such as dementia, epilepsy, swallowing difficulties, diabetes and decreased

mobility) that required staff support and supervision. Documented incidents outlined that residents had alerted staff to a resident falling while having a seizure, and on another occasion to a resident leaving the centre without staff knowledge. Observations and a review of residents' activity records also showed that opportunities to be involved in their local community and activities of their choice were limited by the staff support available. Activities and community participation will be discussed further in the next section of this report. In addition to the insufficient staffing ratios, there were also three staff vacancies at the time of this inspection and at least three staff on long term leave. It was also identified that the number of nursing staff provided in one house was not in line with the nursing levels outlined in the centre's statement of purpose.

Following the last HIQA inspection of this centre in October 2020, the provider outlined that an allocations officer was to liaise with human resources and finance departments to examine ways to ensure the staffing levels in place were appropriate to support all residents. It was also documented in that compliance plan that the need to examine the skill mix and number of staff had been highlighted to senior management. There was no evidence that any effective actions had been taken to address these longstanding staffing issues.

As outlined previously, the staff training matrix had not been maintained. The inspector reviewed the training matrix available in the centre. This did not include records relating to training in the safe administration of medication or infection prevention and control (IPC). Records available related to 37 staff. None had up to date training in the management of behaviour that is challenging including de-escalation and intervention techniques. 68% of the team required refresher training, while there was no record that 32% of the staff team had ever attended this mandatory training. However, more than half of the team (62%) had completed an online positive behaviour support course. 81% of the staff team required training in fire safety. Although an online training, 62% of the staff team required training in safeguarding residents and the prevention, detection and response to abuse. As no nursing staff worked in two of the three houses, the inspector asked management if they had oversight of how many staff who regularly administered medication in these houses had up-to-date training in this area. Management advised that to their knowledge, none of these staff met that requirement. As a result of this finding, the provider was issued with an urgent action to outline how they would ensure that staff had the required training to ensure residents who were administered medications, including those prescribed to be used on an emergency basis, were safe living in the centre. The inspector then asked to see any medication audits completed in these houses. None were available.

Prior to this inspection, the inspector had reviewed the notifications submitted to HIQA since the last inspection of this centre. On the day of inspection, the records of incidents that occurred in the centre were also reviewed. The provider had notified the chief inspector of occasions when a restrictive procedure was used in the centre, as is required by the regulations. In the course of the inspection it became clear that a procedure that had been reported previously had not been reported in the last two quarterly notifications despite still being in use. When the inspector reviewed the documented incidents that had occurred in the centre in

2022, further incidents which should have been notified to HIQA were identified. These included two safeguarding incidents and an unexplained absence of a resident from the centre. The regulations outline that these incidents are required to be notified within three working days of their occurrence. Three retrospective notifications were submitted by the person in charge following this inspection.

Since the last inspection of the centre, information had been submitted to HIQA outlining residents' dissatisfaction with their access to community based activities in line with the easing of national COVID-19 restrictions. At that time assurances were sought from the provider regarding communication with residents and their representatives, including responses to complaints made in the centre. At that time the provider advised that they had retrospectively logged issues raised as complaints and had committed to logging any future complaints (including those made verbally) and forwarding them to the Complaints Coordinator. It was also referenced in an April 2021 report written following an unannounced visit to the centre that management staff had assured the provider's representatives that they would process recently made verbal complaints in keeping with the provider's complaints policy. The inspector asked to see the complaints log for the centre. Only one complaint had been documented and was dated September 2020. When asked if there had been any more recent complaints, management advised that there had been but that these had not been documented. They were therefore not subject to the provider's complaints policy. It was evident that the provider's complaints policy was not being implemented in this centre.

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. Although this document met the requirements of the regulation, in the course of the inspection it was found to be inaccurate. As previously outlined the number of staff working in one house was not consistent with the levels documented. It was also identified that some practices, including regular residents' meetings and the documenting of complaints, outlined in the document were not implemented in the centre.

The provider had been assessed as not compliant with the regulation regarding governance and management in the last two HIQA inspections of this centre completed in April 2019 and October 2020. Findings on the day of this inspection indicated poor compliance with the regulations and insufficient oversight and management arrangements in place. As a result the provider was issued with an urgent action to provide assurance as to how management systems in the designated centre ensured that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Regulation 15: Staffing

The number and skill mix of staff was not appropriate to the number and assessed

needs of the residents and the statement of purpose. The number of nursing staff in one house in the centre was not in line with the levels outlined in the statement of purpose. In other parts of the centre one or two staff regularly supported 11 or more residents. These staffing levels were not appropriate to these residents' assessed and increasing needs.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff did not have access to appropriate training, including refresher training, to meet the assessed needs of the residents. Accurate information was not available regarding staff training in the safe administration of medication, including emergency medication prescribed for the treatment of epilepsy. Staff required this training to ensure residents were safe living in the centre. From the records available, 81% of the staff team required training in fire safety and 62% of the staff team required training in safeguarding residents and the prevention, detection and response to abuse. Training in the management of behaviour that is challenging including de-escalation and intervention techniques was also required by a large portion of the staff team.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not sufficiently resourced the centre. As the been identified previously there were insufficient staffing and management arrangements. The management systems in place did not ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. There was poor oversight in many areas of the service provided including complaints, staff training, residents' individual assessments and planning, risk management procedures and safeguarding. Staff supervision was not occurring in line with the provider's own policy. The annual review did not involve consultation with the residents or their representatives. Where areas requiring improvement had been previously identified in HIQA inspections and in visits completed by representatives of the provider, there was no evidence that actions had been taken to address them.

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all adverse incidents or uses of restrictive procedures that occurred in the centre were notified to HIQA, as is required by this regulation.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider's own complaints policy was not implemented in the centre. The registered provider had not ensured that a record was maintained of all complaints including details of any investigation, the outcome of complaints, any actions taken on foot of the complaints and whether or not the complainant was satisfied.

Judgment: Not compliant

Quality and safety

The inspector found that the quality and safety of care and support provided in the centre required significant improvement. The inspector's observations and a review of documentation indicated that the service provided in parts of the designated centre was neither safe nor appropriate to residents' needs. Additional resources were required to ensure residents could participate in activities in line with their interests and abilities. However, all residents who spoke with the inspector expressed satisfaction with the centre.

The inspector reviewed a sample of the personal plans in place for the residents living in the larger houses. A comprehensive assessment of residents' health, personal and social care needs had not been completed on an annual basis, as required by the regulations. The majority of documents in residents' personal plans had not been reviewed or updated in the previous 12 months. Many documents were last reviewed in 2019. Records of an annual, multidisciplinary review of residents' personal plans were not available. None of the personal plans selected included a current personal development plan. There was no evidence that residents' goals developed in 2019 had been reviewed or progressed. Not all residents had an intimate and personal care plan. The inspector had been informed that one resident had been diagnosed with dementia 15 months prior to this inspection. This was confirmed by reading their medical notes. Although staff were aware of it, there was no reference to this diagnosis, or support plans regarding their associated assessed needs, in this resident's personal plan.

There was evidence that referrals had been made to multidisciplinary professionals requesting additional supports for some residents. The person in charge advised

that residents had received multidisciplinary assessments, recommendations and supports. However, these were not available or referenced in residents' personal plans to guide staff in providing the required supports to meet these residents' assessed needs.

Health action plans had not been maintained or reviewed within the last 12 months. A number of residents living in the centre had a diagnosis of epilepsy. However, not all had an epilepsy support plan. Some residents were prescribed emergency medication to be administered in event of a seizure. This was not always reflected in residents' epilepsy health action plans. It was stated in one resident's personal plan that they were not prescribed emergency medication. However, a review of their medication file indicated this information was incorrect. In another epilepsy plan it stated that staff knew what to do in the event of a seizure. No further guidance was provided. It was also noted that there was no reference to a resident's epilepsy diagnosis on their hospital passport.

The person in charge showed the inspector the recently reviewed personal plan of one resident living in the smaller, single-storey house. All documents and care plans in this file had been reviewed in recent months. It also included a recently written personal development plan. The person in charge advised of their intention to use this personal plan as a template for the other 30 residents living in the centre. They further explained that this was the work to be completed by the staff recently approved to complete additional hours in the centre. While this personal plan was a definite improvement on those selected by the inspector, improvement was still required in the area of epilepsy management and arranging for a multidisciplinary review of residents' personal plans.

The inspector reviewed the centre's risk register and a sample of individual risk assessments. Although the person in charge's concerns about staffing and governance in the centre had been escalated to senior management, associated risk assessments had not been completed. Other hazards, including the low levels of staff training, had also not been risk assessed or considered in other assessments where staff training was documented as a control measure. Individual risk assessments also required review. It was stated on one resident's falls risk assessment that it was to be reviewed every three months due to the high rate of falls. The assessment available in their file was last reviewed over a year prior to this inspection. The person in charge accessed a more recent version on their computer, however this was also reviewed more than three months previously. A review of documented incidents in the centre showed that this resident had fallen twice in the five months before this inspection. It was also identified that risk assessments were not always calculated correctly or reflective of the level of risk in the centre.

When reviewing the record of incidents that had occurred in the centre, the inspector read that it was identified in January 2022 that a substantial sum of money belonging to one resident could not be accounted for. It was not documented what, if any follow up actions had been completed as a result of this discovery. When asked, management were not able to inform the inspector or to advise if the resident's money was found. A provider assurance report was issued

seeking assurances on how the requirements of Regulation 8: Protection were met in the centre regarding this incident. Information received following the inspection provided assurances that this matter would now be addressed. However this information also confirmed that the provider's safeguarding procedures had not been implemented at the time this event occurred.

As outlined in the opening section of this report, the majority of residents attended day services, with three attending classes in the local community and university at times. The inspector reviewed the activity records of seven of the 11 residents living in one house for the month of May 2022. Residents living in this house had spoken with the inspector about a number of community based activities they enjoyed and were interested in. Despite the many skills, interests and abilities of this resident group the only community based activity recorded for any of the residents in May was going for a walk. It was not always clear if this involved leaving the grounds of the centre or if the resident was supported by staff or a family member. Review of these records also indicated low levels of recreation and activities while in the centre. When asked why residents were not involved in more community based activities, the inspector was informed that there were not enough staff to facilitate this.

The inspector asked to review the minutes of residents' forums. According to the statement of purpose and residents' guide documents these meetings occurred monthly in the centre. Management advised that these had not taken place in the previous two years and that it was hoped to restart them in the near future. Given the absence of consultation with residents as part of the annual review, the acknowledged failure to document residents' complaints, the limitations placed on community based activities and the absence of a current personal development plan for most residents, there was little evidence of resident's involvement in the running of the centre or opportunities for choice and control.

As outlined in the opening section of this report, parts of the centre required maintenance. The maintenance log was reviewed and while some areas were scheduled to be addressed others had not been identified or requested. It was noted that the person in charge was following up regarding a concern they had identified regarding fire doors in the kitchen area of each house in the centre. Damaged surfaces, including torn fabric on chairs and couches, were observed throughout the centre. These posed a challenge to maintaining good Infection Prevention and Control (IPC) standards in the centre, as these surfaces could not be effectively cleaned.

The inspector reviewed COVID-19 information available in the centre. This did not include the most recent guidance issued by public health. Although a self-assessment and various checklists regarding IPC had been completed in the centre, it was not clear if follow-up actions had been completed. The centre's COVID-19 contingency plan did not detail what staff were to do in the event of a suspected case in the centre. Specific guidance regarding the personal protective equipment to be used was also not included. Records regarding staff training in hand hygiene and other IPC procedures were not available. The person in charge advised of that one member of the team was a hand hygiene assessor and was in the process of

reviewing all members of the staff team. It was not known on the day of this inspection how many staff had been assessed. While in the centre, the inspector observed many staff wearing surgical rather than respirator masks. When asked about this, the person in charge advised that in line with national guidance staff wore respirator masks when supporting residents within a two metre distance. This was not consistent with the inspector's observations on the day.

Regulation 13: General welfare and development

Residents were not provided with opportunities to participate in activities in line with their individual interests. Activity records did not reflect individuals' preferences. There were very limited opportunities for residents to be supported by staff to engage in activities outside the centre, thereby impeding their abilities to develop and maintain links with the wider community.

Judgment: Not compliant

Regulation 17: Premises

Parts of the centre were observed to be unclean. Areas requiring maintenance were also identified. There was insufficient storage in one house in the centre, as demonstrated by the storage of large furniture no longer in use and the drying of residents' clothes in the smaller living room areas.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The scoring of risk assessments required review to ensure that they were calculated accurately and reflective of the risk posed by identified hazards in the centre. Not all hazards in the centre, including the staffing levels, had been risk assessed. It was identified that some of the documented control measures to mitigate against risks, for example staff training, were not in place. Risk assessments were not always reviewed within the stated timelines or following related adverse events, for example a fall.

Judgment: Not compliant

Regulation 27: Protection against infection

A folder of COVID-19 documents was available in the centre. However this did not include the most up to date guidance and information from public health. The COVID-19 contingency plan required review to ensure that it included the steps to be taken in event of a suspected case of COVID-19 in the centre and provided guidance regarding the use of personal protective equipment. One staff member was observed wearing a surgical mask when supporting a resident within a two metre distance. This was not consistent with current public health guidance. The centre was observed to be unclean in places. A number of damaged surfaces were observed in the centre. As a result of this damage, it would not be possible to clean them effectively. All staff did not have up-to-date training in hand hygiene and other infection prevention and control measures.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of residents' health, personal and social care needs had not been completed for all residents on an annual basis, as required by the regulations. Significant changes in residents' presentation and assessed needs were not always reflected in their personal plans. The majority of documents included in the sample of residents' personal plans read by the inspector had not been reviewed in the last 12 months, as is required by the regulations. The most recent multidisciplinary reviews of residents' personal plans were not available. There was no current personal development plan in place for most residents. Although personal development goals had been identified over two years previously, there had been no reviews of or progress noted in achieving these goals.

Judgment: Not compliant

Regulation 6: Health care

Allied health recommendations were not available to the staff teams supporting residents with increasing support needs. From the sample reviewed, epilepsy support plans were either not in place, not accurate, not recently reviewed or did not provide specific guidance to staff. This posed a risk to residents' safety while in the centre.

Judgment: Not compliant

Regulation 8: Protection

A significant amount of one resident's money could not be accounted for in January 2022. This incident had not been reported or subject to the provider's own safeguarding and protection policy at the time of this inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

It was not evident that residents were consulted with and afforded opportunities to participate in the organisation of the designated centre. The processes and mechanisms in place to facilitate this, such as residents' meetings, consultation as part of the annual review and effective complaints management, were not implemented in the centre. Opportunities to exercise choice and control were limited by the staffing resources provided.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City South 3 OSV-0003311

Inspection ID: MON-0031634

Date of inspection: 30/05/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The Registered Provider is committed to ensuring that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose, layout of the designated centre and in line with the current funding allocation.

The Provider has examined the current staffing allocation with the Human Resource and Finance depts. The current staffing allocation is in line with the funding allocation. The PIC will update the SOP to reflect the current nursing level available in the designated centre by the 31st July.

Furthermore, if required following an assessment of need of each resident, a business case will be prepared and an application for additional funding will be submitted to the HSE for additional resources to reflect residents current and future assessed needs.

Actions:
Update SOP by 31st July.
MDT phase 1 assessments to be completed by the 19th August.
If required, business case for additional resources to be submitted to HSE by 30th September.
If business case to HSE is required, follow up with HSE re. Additional Resources to commence from the 3rd Oct.
Personal Support Plans to be completed by 2nd December.
If business case/application for additional resources is submitted to the HSE, a review of the submitted business case will be completed on the 31st January 2023.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
In response to an urgent action the provider ensures the following actions have been taken.
1. Training plan for Medication Management and Buccal training has been completed and is up to date.
2. All relevant staff have completed medication management training since the inspection.
3. All relevant staff have completed Buccal training since the inspection.
4. Excluding staff currently out on long-term absence, 78% of staff have completed fire training since the inspection with the remaining 22% due to complete the training by 28th July. Following this, if there are remaining staff to complete this training a further training date will be arranged.
5. Excluding staff currently out on long-term absence, 73% of staff have PBS training completed. The remaining staff are due to attend PBS training on either the 2nd Aug or September 6th. Following this, if there are remaining staff to complete this training a further training date will be arranged.
6. Excluding staff currently out on long-term absence, 75% have completed Safeguarding training. The remaining 25% of staff are due to complete this by 31st July.
7. Epilepsy protocols, health action plans, risk assessments, medication audits, pharmacy audits and training matrix are completed and up to date.
8. A plan for MAPA and Manual Handling Training will be completed by 29th July.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider will take the following actions to ensure we are compliant with Regulation 23:
1. A specialised team to assess the current and future needs of each resident in CCS3 has been assembled and a meeting of this team has been scheduled.
2. If required a business case supported by the outcome of assessments carried out in step 1 to be written and submitted to HSE for any additional funding for resources. If a business case is submitted to HSE, a review of this application will occur on the 31st January 2023.
3. PIC shall complete a schedule of individual supervision/performance management meetings for staff members to commence in line with Provider Policy, schedule to be completed by 22nd July 2022.
4. Since inspection retrospective complaints have been logged. In relation to monies;

Trust in Care preliminary screening completed and referred to enquiry stage.
5. System for logging complaints now in process in CCS3. Complaints book in each residence and copy of all complaints stored securely in PICs office. Overview document created and managed by PIC and overseen by PPIM. Provider Assurance Report submitted to HIQA 8/06/2022.
6. Following recent interviews, The Registered Provider has appointed both a CNM2 /PIC & a CNM1 on a permanent basis to CCS3.
7. Re. Personal Support Plans, the provider is taking a phased approach to ensure a truly person centred approach is taken in the review and development of these plans. The Personal Support Plan will include at a minimum, a residents Person Centred Plan, Health Care Plan and Communication Profile. The first phase of this approach is a preliminary review of all residents Personal Support Plans which will include meetings with residents and their representatives. This phase will be completed by 19th August. The second phase will include a more detailed engagement with residents in CCS 3 and include upskilling of staff in engaging meaningfully as key workers with residents' goals and aspirations. Residents full Personal Support Plans, including risk assessments, will be fully up to date, accurate, compliant with regulation and person centred by Friday 2nd December.
8. Any allegation, suspected or confirmed case of abuse to a resident will be notified to HIQA within 3 working days via NF06. Incident to be reported to Designated Officer (DO). Preliminary Safeguarding Screening PSF1 to be submitted to HSE safeguarding team within 3 working days. Safeguarding plans will be completed within 3 working days of incident and reviewed within 6 months. Safeguarding meetings will be held with DO every 6-8 weeks from 16th August and all safeguarding plans will be reviewed at this time.
9. Cope Foundation HIQA administrator has requested updated Registration Certificate from HIQA on 30th June.
10. New system to ensure that the correct staff pictures are displayed for residents has commenced. This new system has commenced since last inspection.
11. New overview manager system to ensure oversight and governance to manage actions within agreed timelines.
12. Last 6 monthly unannounced occurred March 10th 2022. 6 monthly and annual reports and action plans will be available to staff.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
PIC has submitted all notifications to HIQA and HSE Safeguarding retrospectively. Two NFO6 notifications have been submitted and one NF05 notification has been submitted retrospectively. Updated rights restriction information will be included in next NF 39, which is due on the 31st July.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. New system for logging complaints now in progess in CCS3. There is a Complaints book in each residence and a copy of all complaints stored securely in PICs office. Overview document created and managed by PIC and overseen by PPIM. Provider Assurance Report submitted to HIQA 8/06/2022.
2. As part of the policy of the month initiative, PIC has assigned the Complaints Policy to be read, understood and signed by all staff by 31st July.
3. Review of complaints to become an agenda item for staff meetings.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The registered provider will carry out the following to ensure we are compliant with Regulation 13:

1. An assessment of need of each resident. Phase 1 to be completed by 19th August 2022.
2. Update Person Supports Plans to be completed 2nd December.
3. Following assessment of need, submit business case, if required, to the HSE for additional resources to reflect residents current and future assessed needs.
4. The Person Centred Planning Process will be completed by the PIC and Key Worker to involve the resident and their chosen representative to identify opportunities to participate in activities in the wider community in accordance with their wishes, interests, capacities and development needs. Person Centre Plans to be completed by 2nd December.
5. Positive outcome of this regulation will be dependent on assessment of need outcomes which may identify the need for additional resources and expertise.
6. If business case is submitted to HSE for additional resources, a review of the submitted business case to be completed on January 31st 2023.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The register provider will take the following actions to ensure compliance with Regulation 17:

1. Facilities manager and PIC have completed a walk-through of CCS3 and compiled a list of works for completion.
2. Facilities manager has requested all relevant trades to price the relevant works accordingly.
3. PIC to source quotes for new furniture to be in compliance with IPC guidelines.
4. Fortnightly audits by cleaning contractor to be completed for approx. a three-month period (commencing Week ending 10th July and finishing 30th September). Following this audit period, the registered provider will review the findings and evaluate the cleaning regime.
5. Solutions for storage and drying of clothes have been identified as part of the list of works for completion.
6. Review of relevant works to be completed on the 16th December 2022.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
PIC and newly appoint CNM1 to complete Risk assessment training by 19th August. Following this PIC and CNM1 will provide training to CCS3 Team. Relevant staff members will have risk assessment training completed by 30th September.

The PIC and CNM1 will carry out a preliminary review and develop a schedule to update all risk assessments by 19th August. Key workers will hold responsibility for ensuring all individual risk assessments are updated in line with schedule. PIC and CNM1 to oversee and manage in line with time frames. All risk assessments will be up to date by December 2nd.

The PIC to update risk register to include staffing levels. This will be completed by 30th September.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: Since inspection the Covid-19 folder has been updated with the most recent guidelines and information from Public Health. The Covid 19 contingency plan has been reviewed to ensure all information reflects current public health guidelines. Contingency plan updated to include measures in the event of a suspected Covid-19 case. Staff members have been reminded to ensure they are compliant with the most up to date public health guidelines in relation to PPE / mask wearing. IPC audits to be completed as per audit schedule. Facilities manager and PIC have completed a walk-through of CCS3 and compiled a list of works for completion. Fortnightly audits by cleaning contractor to be completed for approx. a three-month period (commencing Week ending 10th July and finishing 30th September). Following this audit period, the registered provider will review the findings and evaluate the cleaning regime. All staff have completed IPC training on HSEland and onsite hand hygiene assessor has been requested by PIC to ensure that all staff present have completed hand hygiene. This will be completed by the 29th July.	
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: Individual assessments of current and future needs of all residents is currently underway to include the MDT and will support both residents Personal Plans as well as possible business cases requesting an increase in resources. If a business case is submitted to HSE, there will be a review of this submission on the January 31st 2023. Re. Personal Support Plans, the provider is taking a phased approach to ensure a truly person centred approach is taken in the review and development of these plans. The Personal Support Plan will include at a minimum a residents Person Centred Plan, Health Care Plan and Communication Profile. The first phase of this approach is a preliminary review of all residents Personal Support Plans which will include meetings with residents and their representatives. This phase will be completed by 31st August 2022. The second phase will include a more detailed engagement with residents in CCS 3 and include upskilling of staff in engaging meaningfully as key workers with residents' goals and	

aspirations. Residents full Personal Support Plans including risk assessments will be fully up to date, accurate, compliant with regulation and person centred by Friday 2nd December. Safeguarding plans will be completed within 3 working days of incident and reviewed within 6 months. Safeguarding meetings will be held with DO every 6-8 weeks from 16th August and all safeguarding plans will be reviewed at this time.

Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: All residents with epilepsy have up to date health action plans, risk assessments and protocol in place. This has been completed since inspection as outlined in urgent compliant plan. Evidence based document has been created to capture and track allied health professional referrals, recommendations, actions and outcomes. Document has been created since inspection and will be populated with current and future resident needs. This will be up to date by Aug 19th. Health Care plans will form part of the completed Personal Support Plan due for completion by the 2nd December 2022.	

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: As per provider assurance report (8th June and update on the 13th June with actions following case conference), policy was followed retrospectively for incident regarding monies missing. Notifications were submitted to HIQA and HSE Safeguarding on the 9th June. Case Conference was held on the 9th June and was reviewed on the 6th July. Following Trust in Care preliminary screening, this matter has now been referred to HR department for enquiry. Residents money has been refunded by Cope Foundation. Gardai have been notified of the issue. Safe has now been installed in the Managers office. Management team only have access to safe. Requisition protocol in place for residents to access monies in the absence of management team. All actions from Case Conference are now complete.	

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Monthly resident's forum meetings have been scheduled for CCS3. These will commence the week ending 31st July. The resident's forum, will allow for consultation and provide real opportunities for residents to have their voice heard and to fully participate in the running of CCS 3. Business case to be submitted if required following assessment of need, to the HSE for additional resources to enhance residents' opportunities to exercise choice and control of their lives. If business case is submitted to HSE, a review of this submission will occur on the 31st January 2023.	

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)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	31/01/2023
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.	Not Compliant	Orange	31/01/2023
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with	Not Compliant	Orange	31/01/2023

	their wishes.			
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	31/01/2023
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	31/01/2023
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.	Not Compliant	Red	30/09/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	16/12/2022

Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	16/12/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	16/12/2022
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	31/01/2022
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	Red	29/07/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	02/12/2022
Regulation	The registered	Not Compliant	Orange	30/09/2022

23(2)(a)	provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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	30/11/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Not Compliant	Orange	02/12/2022

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/09/2022
Regulation 31(1)(e)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any unexplained absence of a resident from the designated centre.	Not Compliant	Orange	09/06/2022
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse	Not Compliant	Orange	09/06/2022

	incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2022
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	31/07/2022
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	31/07/2022
Regulation 34(2)(e)	The registered provider shall ensure that any measures required	Not Compliant	Orange	31/07/2022

	for improvement in response to a complaint are put in place.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	31/07/2022
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	02/12/2022
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	Not Compliant	Orange	31/01/2023

	accordance with paragraph (1).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	03/06/2022
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	02/12/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	02/12/2022

Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	02/12/2022
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	09/06/2022
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	31/01/2023
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.	Not Compliant	Orange	31/01/2023