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 7
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	09 February 2023
Centre ID:	OSV-0003297
Fieldwork ID:	MON-0030113

About the designated centre

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

Cork City North 7 comprises four houses on a campus setting in Cork city. There are other designated centres on this campus. The centre currently provides a residential service to 25 people, who live in the centre on a full-time basis. The centre provides services to both males and females, over the age of 18 years.

Each house is a two-storey building with the same layout. This includes a kitchen, separate dining room, sitting room and sun room. Each house has both downstairs and upstairs bedrooms. Some residents in each house share their bedrooms with others. The centre is staffed at all times. The staff team consists of care assistants, nurses and activities coordinators.

The stated aim and objective of the centre, as outlined in the statement of purpose, is to promote a welcoming and homelike environment ensuring always that residents' dignity and safety is promoted.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 9 February 2023	09:20hrs to 21:15hrs	Caitriona Twomey	Lead
Thursday 9 February 2023	09:20hrs to 21:15hrs	Deirdre Duggan	Support

What residents told us and what inspectors observed

Cork City North 7 comprises four houses on a campus setting in Cork city. There are other designated centres, and a day service operated by the provider on this campus. Each house is a two-storey building with the same layout. This includes a kitchen, separate dining room, sitting room, conservatory, and laundry room. Upstairs there was a staff office. There were three downstairs, and two upstairs, bedrooms in each house. 10 residents shared their bedrooms with one other person. There were no longer shared bedrooms in two of the houses. A full-time residential service is provided to both males and females, over the age of 18 years.

This centre is run by Cope Foundation. Due to concerns in relation to Regulation 23 Governance and management, Regulation 15 Staffing, Regulation 16 Training and staff development, Regulation 5 Individualised assessments and personal plan and Regulation 9 Residents' rights, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in October 2022 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan the provider has provided an action plan to the Chief Inspector highlighting the steps the provider will take to improve compliance in the provider's registered centres. These regulations were among those reviewed on this inspection and the findings will be outlined in this report.

Although registered to accommodate 30 residents, at the time of this inspection there were 25 residents living in the centre. When the registration of the centre was last renewed, two additional conditions were applied by the Chief Inspector. One related to no new admissions to the centre until a plan to move some residents to community-based services had been implemented. The other specified that the provider would adhere to the timelines outlined in the decongregation plan submitted to the Chief Inspector. Since then the provider had requested an extension to the date by which this plan would be implemented. The decongregation plan outlined that in total 16 residents would move to homes of their own in the community over a four year period. The first group of four residents was to move by the end of March 2022, with the other three groups of four residents due to move by March 2023, March 2024 and March 2025 respectively.

This was an announced inspection. On arrival the inspectors were welcomed by the person participating in management and met with the person in charge shortly afterwards. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspectors and all staff adhered to these throughout the inspection. Initially inspectors met with members of the management team before spending time in each of the four houses, and speaking with some residents' relatives.

In the opening meeting, it was confirmed to inspectors that the centre's

decongregation plan had not been implemented as planned. To date, no residents had moved into community-based services and there was no time-bound plan in place for when this would happen. Therefore the provider was not operating the centre in line with one of its registration conditions. Management explained that it had been agreed at a senior management level to review and restart the centre's decongregation plan, beginning in February 2023. The provider had an overall decongregation plan for a number of centres and to support this process, a person had been hired to source houses in the community. A transition coordinator had also been employed. Management advised that due to their changing needs, the move of two residents to other centres operated by the provider was being considered. It was planned to re-assess the needs of all of the current residents in the centre in the coming months to inform any possible moves to new, or other, designated centres. The group of four residents identified to move first remained unchanged. Two of these residents currently lived in the same house. The activity coordinators knew of the planned move to the community for these residents and to facilitate this, arranged activities most often with two or three members of this group. Records indicated this had happened on 11 occasions in the previous nine months. Since the last inspection, the number of residents living in the centre had reduced by four due to changes in circumstances. As a result there were no longer any shared bedrooms in two of the houses.

Inspectors were separately accompanied to visit one house by a member of the management team and each visited a second house later that afternoon. It was noted that one house was particularly busy and it was felt that the inspector's presence was having a negative impact. As a result the inspector spent only a brief amount of time in this house and reviewed documents and information relating to the house and the residents who lived there in an administrative building on the campus.

All four houses were observed to be warm, welcoming and decorated in a homely manner. Residents' photographs were on display in communal areas and some of the houses had been recently painted, and provided with new couches and other furniture. An inspector saw a fish tank in one sitting room and was told that one resident liked to feed the fish. In another house, the conservatory area was fitted with lights and a projector which was used to show films on the wall. Staff advised that some residents especially liked to spend time in this area and found it relaxing. Televisions and radios were available in all four houses. Kitchens were well-equipped and well-organised. It was identified that some areas in the houses required maintenance. These included damaged flooring, rusted bathroom fittings, a damaged tile and shower panel, damaged surfaces on shelves and storage units, and a window blind that required cleaning or replacement. Some of these had been previously identified by management and works had been requested using the provider's internal system. In general the houses were observed to be clean, although additional cleaning was required in one house in particular. Management advised that a 'deep clean' had already been requested for this house.

The inspectors saw some residents' bedrooms. These had been personalised to reflect residents' interests. Photographs, and residents' preferred items were on display. Staff advised that it was a current goal for some residents to decorate their

bedrooms and put up family photographs. As referenced previously, ten residents shared a bedroom with one other person. In these rooms, each resident's own area in the room was clearly outlined, as were their facilities to store their belongings. Some, but not all, shared bedrooms were divided with a partition wall. In the other shared rooms a retractable privacy screen was available for use should it be required. Staff advised that this was most often used to support residents' privacy and dignity during personal care tasks. The inspectors saw bedrooms that had been shared in the past but were now single occupancy. One resident now had a couch in their bedroom where they enjoyed sitting by the window. This resident was sitting on this couch when the inspector met with them. Other previously shared bedrooms, now had a small sitting room area. Residents enjoyed using and spending time in these spaces and they too had been personalised. The person in charge told the inspector that for one resident this arrangement was more similar to the resident's family home environment where they had lots of space to themselves.

There were 25 residents in the centre on the day and inspectors had a chance to spend some time with 24 of them. One resident was resting in their bed when the inspector was in the house where they lived. Residents appeared at ease in the centre and with the staff support provided. Residents appeared to gravitate to their preferred areas in the houses where they lived. An inspector was introduced to one resident who was sitting on a couch in their bedroom. Management explained that they enjoyed being near the window and since the couch was brought into their bedroom (this room had previously been shared with a peer), they often spent time there. Others were sitting in the dining room being supported by staff to eat or participate in activities, such as making cards and looking at photos on their electronic tablet. In the sitting rooms and conservatories some residents were sitting or lying on the couches available. Music was playing in some rooms and televisions were on in others. One resident had an interest in the newspaper and went in search of that day's edition. Another was standing in the kitchen, it was explained that this resident preferred the company of staff to their peers. Four residents returned to one house while the inspector was there. They had been out for coffee and gone for a walk in a coastal town. Residents had their supper later that evening. As eight residents lived in this house, staff offered supper to four residents at a time. This staggered approach worked well as it enabled all residents to receive the level of support and supervision they required. There was a warm and light-hearted atmosphere at the table as residents chose and ate their supper. Other residents had gone to the cinema on the day of the inspection. In other houses residents were also observed relaxing in communal areas and their bedrooms, taking part in table top activities such as crafts and games, knitting, singing, and chatting with staff.

The centre is staffed at all times. Staffing levels in the centre will be discussed in the 'Capacity and capability' section of this report. The staff team consists of two activity coordinators, care assistants and nurses. Inspectors met with a number of staff during the inspection. All interactions observed and overheard were warm, unhurried, and respectful. Staff appeared to know residents well and were enthusiastic about working in the centre.

As this inspection was announced, feedback questionnaires for residents and their

representatives were sent in advance of the inspection. 14 were returned to the inspectors. Some had been completed by residents with support from others, and others by residents' relatives. Overall the feedback received was positive. Respondents were positive about their homes, with some mentioning their bedrooms and the outdoor areas, and others referencing that they enjoyed when the centre was decorated for St Patrick's Day, Christmas, and other festive occasions. However, one respondent expressed their wish that the provider receive more funding to upgrade the facilities. Nearly all respondents referenced that residents enjoyed going on trips, for coffee, and spending time outside the campus. Some respondents referenced that residents would like to go out more often. One respondent referenced that a resident prefers one-to-one interactions as they find groups daunting. It was later identified that this person lives in a house with seven other residents. Staff were regularly praised in the questionnaires and were described as caring, attentive, approachable, easy to talk to, helpful, welcoming, friendly, pleasant, accommodating, professional, understanding and fantastic. They were also praised for keeping in touch with relatives. There was positive feedback regarding a Christmas party held in December 2022 for residents, their friends and family, and staff. This had not occurred for a number of years due to the COVID-19 pandemic and its return was welcomed.

In addition to these questionnaires, relatives of five residents either met with or spoke with inspectors on the day. Again the feedback received was positive. Relatives outlined how challenging the COVID-19 pandemic had been for them and their relatives, especially at times of national restrictions when visits were not possible. The service was praised for keeping residents safe. The efforts made by staff to maintain contact were also praised but although electronic options were tried, they were not always suitable for residents, and were no replacement for in-person contact. References were made to window visits, regular calls with the staff team, and relatives dropping things up to the centre for residents. Relatives were happy with the level of contact and communication they received, and advised that this had been discussed with them by management. Some reported that they now received more information than ever before and welcomed this. One person spoke with an inspector about how much they and their relative welcomed that their relative no longer shared their bedroom, highlighting how it contributed to the resident's experience and feelings of independence. All relatives spoken with expressed that they would be comfortable to raise any concerns or queries with members of the staff or management team. They felt that any matter they raised was taken seriously and considered. For some this was also an improvement on their previous experiences. One person expressed that they felt their relative's, a resident, input was now more regularly sought and listened to in the centre. This was very important to them and, they felt, a significant improvement. As in the questionnaires, relatives were very appreciative and positive when speaking about the staff team. One person was especially appreciative of an offer made to give them copies of recent photographs of their relative.

As well as visiting all four houses, spending time with residents, speaking with staff and some relatives, the inspectors also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the four 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. A review of a sample of rosters indicated that staffing in the centre was not in line with the planned roster or the staffing levels outlined in the statement of purpose. Staff training records were also reviewed which indicated good oversight and timely access to mandatory training. The centre's complaints logs and records kept regarding residents' personal finances were also reviewed. In addition inspectors looked at a sample of residents' individual assessments and plans in each house in the centre. These included residents' personal development plans, healthcare and other support plans. Any identified areas for improvement will be outlined 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

As referenced in the opening section of this report, the provider had not implemented the decongregation plan they had previously submitted to the Chief Inspector within the specified timelines. As a result they had not operated in line with the centre's registration conditions. There were repeated non-compliances with the regulation regarding staffing in this centre. It was also identified that not all adverse events that occurred in the centre had been reported to the Chief Inspector, as required. Aside from these matters, there was also evidence of good oversight of the service provided to residents.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. Care staff and activity coordinators reported to nursing staff, who reported to a nurse manager, who reported to the person in charge. They reported to the person participating in management.

The person in charge was employed on a full-time basis and worked in this centre only. Although their role was supernumerary, they also provided direct support to residents as required. At the time of this inspection the nurse manager had been on leave for over two months and was not expected to return this year. Management advised that this position was to be filled, and that interviews were scheduled in the coming weeks. The person in charge was based on the campus and regularly visited each of the houses. They clearly knew the residents well and were knowledgeable about their assessed needs and the day-to-day management of the centre. There was evidence that regular staff meetings, and one-to-one meetings as part of the provider's performance management system, were taking place. These provided staff with opportunities to raise concerns they may have about the quality and

safety of the care and support provided to residents, as is required by the regulations.

The provider had completed an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in August 2022 and involved consultation with residents and their representatives, as is required by the regulations. Unannounced visits had taken place in February and November 2021 and again in April and October 2022. Where identified, there was evidence that areas requiring improvement were being progressed or had been completed, for example staff had since completed mandatory training and residents' healthcare management plans were updated. The person in charge was also competing a number of other audits in the centre and spoke with the inspectors about areas for improvement that they had identified through these audits.

In advance of this inspection, the inspector reviewed notifications that had been submitted regarding this designated centre to the Chief Inspector. In the course of this inspection, inspectors identified two adverse incidents and an environmental restriction used in the centre that had not been reported to the Chief Inspector, as required by the regulations. A retrospective notification regarding one of these incidents was submitted prior to the close of this inspection.

An effective complaints procedure was in place. A review of the complaints log for each house demonstrated that any complaints made were investigated promptly, measures required for improvement were put in place, and the satisfaction of the complainant was recorded. One complainant was very appreciative of how the concern they raised was addressed which resulted in the introduction of a less invasive healthcare monitoring system for a resident. They had sent a card to management expressing their gratitude. There was one open complaint at the time of this inspection. Processes were underway to address the matter raised.

A review of training records indicated that there was good oversight in this area and the majority of the staff team had recently attended training in the areas identified as mandatory in the regulations. These included fire safety, training in the management of behaviour that is challenging including de-escalation and intervention techniques, safeguarding residents and the prevention, detection and response to abuse, and infection prevention and control. Any outstanding training was to be completed in the coming days. The staff team had also recently completed training in a human rights-based approach in health and social care, and in the HSE (Health Service Executive) national consent policy.

Staffing was identified as an area requiring improvement in four of the five most recent inspections of this centre. It remained a challenge at the time of this inspection. Management advised that recruitment was ongoing and that although staff had been hired, staff resignations and various types of leave meant that it was difficult to maintain the required staffing levels. An inspector requested the planned and actual staffing rotas for each house in the centre. They then reviewed these rotas for two separate weeks, selected at random, in the previous six months. On review, it was identified that in both weeks the staffing levels were consistent with

the planned roster on only two of the seven days. As was referenced in previous inspections, and acknowledged by the provider, the practice of locking the kitchens in two houses at times due to available staffing levels continued.

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. This document met the majority of the requirements of the regulations. Some revision was required to ensure that all staff working in the centre were included in the organisational structure of the centre, that staffing was outlined in whole-time equivalents (WTEs), and to include additional information regarding the emergency procedures in the centre. This revision was completed before the close of the inspection.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to register this centre in line with the requirements outlined in this regulation.

Judgment: Compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The registered provider had paid the annual fee outlined in this regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis, and had the skills, qualifications, and experience necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

From the records reviewed, the number of staff working in the centre was regularly not consistent with the staffing levels outlined in the statement of purpose, or the

residents' assessed needs. The practice of, at times, restricting residents' access to the kitchen in two houses due to the number of staff available continued. It was also noted that although included in the planned rosters, the hours worked by the activity coordinators were not included in the actual staffing rosters.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff had recently attended the majority of trainings identified as mandatory in the regulations. Outstanding training was scheduled for the days following this inspection.

Judgment: Compliant

Regulation 22: Insurance

The registered provider ensured that insurance against injury to residents was in place.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not complied with one of the registration conditions of this designated centre, namely to comply with the time lines outlined in the decongregation plan submitted to the Chief Inspector. The centre continued to be insufficiently resourced to ensure that the service provided was consistent and appropriate to residents' needs. Some areas requiring increased oversight were identified including the awareness of adverse incidents and reporting them to the Chief Inspector, as required by the regulations.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that the organisational structure included all staff working in the centre, the staffing complement was

outlined in whole-time equivalents (WTE), and emergency procedures in the event the centre was uninhabitable were included. The statement of purpose was revised, addressing these points, during the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all adverse incidents or uses of environmental restraints in the designated centre were notified to the Chief Inspector, as required by this regulation. Each occasion that some environmental restraints were used was also not recorded or notified.

Judgment: Not compliant

Regulation 34: Complaints procedure

An effective complaints procedure was in place. A review of the complaints logs for each house demonstrated that any complaints made were investigated promptly, measures required for improvement were put in place, and the satisfaction of the complainant was recorded.

Judgment: Compliant

Quality and safety

While improvements were noted since the last inspection of this centre, some areas requiring further improvement were identified by inspectors. It was acknowledged that the overall support needs of the resident group living in this centre were increasing. Residents' ages ranged from 37 to 72 years old. 17 of the 25 residents living in the centre were aged 50 or older. Three residents had a dementia diagnosis. According to the provider's annual review, over half of the incidents recorded in the centre were either slips, trips or falls. In one house, it was noted that one resident was at least 12 years younger than their peers. This resident was very active and as a result had been reported to unintentionally cause other residents to fall in the centre. Information included in some residents' personal plans indicated that the designated centre was not suitable for the purposes of meeting their needs.

The inspectors reviewed a sample of the residents' assessments and personal plans.

These provided guidance on the support to be provided to residents and had been recently reviewed. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and preferences, personal care, healthcare and other person-specific needs such as mealtime support plans. Although a lot of information was available, it was noted that where needs were identified, corresponding supports were not always included in residents' personal plans. Examples identified by inspectors included that there was no plan in place to support a resident who experienced difficulties going between the centre and their family home, and a resident assessed as being at high risk for falls who did not have a mobility support plan. A multidisciplinary review of each plan had been completed in the previous 12 months, as is required by the regulations. These reviews were comprehensive and included recommendations arising out of the review and those responsible for following up on them.

Residents' healthcare needs were generally well met in the centre. Residents had an annual healthcare assessment. A summary document had been developed for each resident to be brought with them should they require a hospital admission. Records were available regarding residents' vaccination status. In most cases, where a healthcare need had been identified a corresponding healthcare plan was in place. As was found regarding other assessed needs, there were some exceptions to this where an inspector noted that a condition was referenced in a resident's healthcare assessment but a related plan was not in place. Similarly, it was noted that one resident had gained 14kg in the previous two years and was now assessed as obese. There was no plan in place regarding this and no referrals had been made to access specialist support regarding this matter. There was evidence of input from, and regular appointments with, medical practitioners including specialist consultants as required. There was also evidence of input from health and social care professionals such as speech and language therapists, physiotherapists, and dieticians. A number of residents also had mental health support plans. It was noted that these were very narrow in focus and referenced medication and medication reviews only, rather than talking a more holistic approach to residents' mental health needs. It was noted that while some residents had received a recent review of their dental health, this was not the case for all residents who required it. Some residents had not had an oral hygiene review by an appropriate professional since 2019.

A sample of behaviour support plans were reviewed. They had been recently reviewed and outlined proactive approaches to prevent or reduce the likelihood of an incident occurring, and also response plans to be implemented if required. Although in place for some, not all residents who required a behaviour support plan had one in place. A number of residents in the centre had safeguarding plans in place. There was evidence that these were regularly reviewed by the person in charge. They advised that they also met regularly with the provider's designated officer to discuss any safeguarding concerns and plans. On review of one plan, it was noted that it was stated that the person alleged to cause concern, a resident of the centre, had a positive behaviour support plan in place. However, this was not the case. A referral had been made requesting this support.

As referenced in the opening section of this report, an inspector spent a brief

amount of time in one of the houses. This house was observed to be very busy when all the residents and staff were present, although there were a number of communal areas to spend time in. Following the inspectors arrival to this house, staff took one resident for a walk and this did reduce the activity levels in the house briefly. When reviewing the personal plan of a resident who lived there, the inspector noted that it was documented that they required a calm environment. From the inspector's observations, such an environment was not available in their home at certain times of the day.

A number of residents had documented recommendations regarding feeding, eating, drinking and swallowing. These had been recently reviewed. Staff spoken with were very knowledgeable about these assessed needs and the supports to be provided. When in the houses it was noted that the main meal of the day was not prepared in the centre from Monday to Friday. Instead it was delivered from a kitchen on another campus operated by the provider. There was evidence of food choices being made available to residents on the day of this inspection, and records outlined the foods eaten previously. Some residents were supported to be involved in parts of food preparation. On the day of this inspection, residents in three houses had been supported to make chocolate crispy cakes.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. In contrast to the last inspection, all residents had a current personal development plan. Personal development goals outlined what each resident wanted to achieve in the year. Many residents' most recent meetings to develop these plans had taken place in recent weeks. In the previous year, residents had been supported to achieve goals that were meaningful to them. These included returning to swimming, going on holiday, and staying overnight in a neighbouring county to spend time with a relative. For some residents, it was difficult to assess what progress had been made in achieving their 2022 goals. Although goals had been clearly outlined at the start of the year, there was no documented progress or explanation as to why this had not taken place. Current goals were noted to be personal to the residents and reflected their interests and things that were important to them.

Family members had been invited to attend these planning meetings and their input was recorded. Contact with friends and family was important to many of the residents in the centre and this was supported by the staff team. Relatives were welcome in the centre and staff also supported residents to visit their family homes. Some residents regularly stayed overnight with relatives, most often at the weekends. A visitors' room had been made available for use in another building on the campus. One resident's relative was very positive about this facility when speaking with an inspector.

Inspectors were informed that the day service located on the campus became available to residents again before Christmas 2022. Management advised that typically residents went to the day service if there was a particular activity they wished to participate in, rather than routinely attending for the whole day from Monday to Friday. At the time of this inspection less than half of the residents living in the centre regularly attended the day service. There were two activity

coordinators working in the centre from Monday to Friday. Each was assigned to two houses meaning that they were assigned to work with 12 or 13 residents on any given day. Where possible, residential support staff worked with them to facilitate activities in the centre and also in the residents' local community. Each resident had their own personal folder of photographs showing them participating in a variety of activities. Some residents had participated in a series of dance classes that were held on the campus. This was reported to be very enjoyable and it was hoped that something similar would be arranged again. Centre-based activities included painting, reading the paper, music, and baking. Community-based activities included going for walks, shopping, for coffee, to an animal sanctuary, to the seaside and the cinema. From a review of the activity records maintained for each resident, it was identified that the most commonly recorded activities were going for a spin or a walk. It was also noted that not all residents engaged regularly in activities outside the campus. For example, recent activity records for one resident indicated that they had left the campus to participate in community-based activities approximately once per month.

Many staff working in this centre were not trained to, and therefore did not, administer medicines to residents. Management advised that some staff had requested this training to support their professional development and these requests would be supported. The planned roster scheduled for at least two nurses to be on duty in the centre by day and one by night. Therefore even if staffing was provided as planned, there was a practice of staff leaving one house to administer medicines in other houses in the centre. An inspector reviewed the medication management processes in place in one house in the centre with one staff members. They were very knowledgeable about the systems in place. Medicines were stored in a secure, dedicated area in each house. It was noted that there were not designated storage spaces for each resident and unopened medications belonging to all residents were stored together. There was only one medication refrigerator in the centre. This was observed to be clean and records indicated that its temperature was monitored regularly. Again, storage in the refrigerator was not designated or separated, with medicines prescribed for residents living in all four houses stored together on one shelf. Medication audits were completed, including one completed by the residents' pharmacist. On review of one resident's prescription, it was observed that the typed maximum dose to be administered in 24 hours of a PRN medicine (a medicine taken only as the need arises) had a line through it, with a different hand-written dose in its place. This was not signed or dated by the prescriber. This practice was not in line with the provider's own medication management policy. It was also identified that PRN protocols were not in place for a number of prescribed PRN medicines. This meant that there was no clear guidance available to staff regarding the administration of these medications.

An inspector reviewed the records maintained regarding residents' finances. The provider's policy outlines that the provider has an implied trustee relationship with residents in respect of their funds and offers services in relation to managing these funds. Documentation was not available in the centre regarding residents' requests, or consent to, the provider managing their finances. The person in charge told the inspector that this arrangement was in place for 20 residents, with relatives of the five remaining residents managing their finances. Management planned to discuss

control of, and access to, finances as part of residents' annual person-centred planning meetings. Records were available regarding cash amounts belonging to the residents. The person in charge explained that for the majority of residents, requests to access money were submitted by management to the provider's finance department. Once received, this amount was lodged in individual resident records and any money spent was logged. This money was stored securely in an administrative building on the same campus as the centre. Only a small number of staff had access to this money. For all residents in the centre, records of any money received and spent (including receipts) were signed by two staff, as was the current balance of money available. The person in charge, and one other staff, also audited the balance and actual money available monthly. From the records reviewed, this system was being implemented as described. Neither staff nor residents were aware of how much money residents had in their accounts. The inspector was advised that this information could be requested and that annual statements were issued. Management were clear on what costs were to be covered by residents and explained that the costs associated with going out for a coffee or an ice-cream were covered by the provider. However, the costs of a meal out or an activity would be paid for with residents' own money. Staff expenses were all covered by the provider.

Management advised that supporting residents to have their own bank accounts was being considered at an organisational level and that it was to trialled in one designated centre this year. The provider had recently appointed an advocacy coordinator and they were due to visit the centre in the coming days. The person in charge spoke of their plan to identify local advocacy champions. Former staff had previously fulfilled these roles in the centre. The person in charge explained that external advocacy organisations had provided training to the staff team in the past. Regular resident forums were taking place and records viewed showed that the frequency of these had recently increased from monthly to weekly. There was evidence also that efforts were made to obtain consent from residents prior to receiving vaccines.

As referenced previously, it was acknowledged that at times the kitchen doors in two houses were locked due to low staffing levels. It was not recorded how often this restriction was used. Management committed to recording and reporting this in future. It was also noted that one restrictive practice, locking a bathroom storage unit, had not been notified. There was evidence that the provider was aiming to use the least restrictive options possible in the centre, for example where previously the door to a room had been locked, now it was freely accessible and one cupboard in the room was locked.

The premises were generally clean and well-maintained, however as outlined in the opening section of this report, some areas required maintenance and additional cleaning. The provider hired a cleaning company to clean each house for approximately two hours from Monday to Friday. Staff working in the centre were responsible for cleaning the centre outside of these times, including at weekends. When reviewing laundry management in the centre, it was identified that the laundry equipment in more than one house required repair, and to be cleaned. Some of the storage units in the utility and other rooms (including bathrooms and a designated store room) were also observed to have damaged surfaces meaning they

could not be cleaned effectively.

As had been identified on previous inspections, due to the number of residents living in some houses and the practice of shared bedrooms, there was limited private accommodation available for residents. This was a particular challenge for those residents identified as requiring or preferring a calm and quiet environment.

Inspectors reviewed some of the systems in place regarding the prevention and control of healthcare-associated infections, including COVID-19. Up-to-date public health guidance was available. Records indicated that staff had recently completed training in infection prevention and control, including hand hygiene. Of the sample reviewed by inspectors, each staff member's hand hygiene practices had been assessed in recent months. Staff were observed completing hand hygiene during the inspection. Supplies of personal protective equipment were available throughout the centre. The provider had a contingency and isolation protocol in place to be implemented in the event of a suspected or confirmed case of COVID-19 or any other transmissible infection. However, the details in this plan were inconsistent regarding the arrangements in the centre should one of the ten residents who shared a bedroom be required to isolate. Management committed to addressing this.

Regulation 11: Visits

Residents were free to receive visitors if they wished and both communal and private spaces were available to facilitate this. A private room in an administrative building on the campus was available at all times to support visits, as requested.

Judgment: Compliant

Regulation 12: Personal possessions

There was good record keeping at a local level regarding any cash belonging to residents that was received or spent while in the centre. The financial accounts of residents who received the provider's support with their financial affairs were managed centrally by the provider. It was not documented that residents' consent to pay their money into an account had been obtained, as is required by the regulations.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The provider employed two activity coordinators to facilitate 25 residents, with support of staff, to participate in activities. While there was evidence of residents participating in activities, opportunities to spend time in the wider community were limited for some residents.

Judgment: Substantially compliant

Regulation 17: Premises

As has been identified on previous inspections, there was limited private space in the centre. This was most noticeable in two of the houses, where seven or eight residents lived, and some shared their bedrooms. Some areas required maintenance and enhanced cleaning to ensure the centre was kept in a good state of repair.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The food provided in the centre was nutritious. Residents were offered and supported to make choices at meal times. Some residents participated in snack preparation or baking. Staff had a good understanding and awareness of residents' dietary needs and supports they required at mealtimes.

Judgment: Compliant

Regulation 20: Information for residents

The residents' guide in place met the requirements of this regulation.

Judgment: Compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare-associated infections including COVID-19. The staff team had completed training in infection prevention and control, including hand hygiene. The centre was observed to be generally clean. However there were some damaged surfaces evident which therefore could not be cleaned effectively. The contingency plan required review to

accurately reflect the arrangements in this centre.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had practices in place relating to the ordering, prescribing, storage, disposal and administration of medicines in the centre. Some improvements were required to ensure that these practices were implemented consistently in the centre. Areas requiring improvement included ensuring that any changes to the dose to be administered to a resident were signed by the prescriber on the prescription. Guidance protocols were not available for all prescribed PRN medicines (medicines only taken as the need arises). Management committed to addressing this.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Some residents had been assessed as requiring a calm and quiet environment however this was not consistent with the environment in the houses where they lived. Assessments and reviews had not been arranged for some residents in the area of oral / dental hygiene. It was identified in some instances that the supports required to meet residents' assessed needs were not always included in their personal plans. These included those assessed with specific medical conditions, as finding transitions difficult, and as being at high risk of falls. While each resident now had a current personal development plan, not all goals had been reviewed in the previous 12 months. It was therefore not documented why the plan in place had not been effective to support residents to achieve their goals.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare needs were generally well met in the centre. Residents had access to healthcare professionals and health and social care professionals in line with their assessed needs. The finding that not all identified healthcare needs had a corresponding healthcare plan is reflected under Regulation 5.

Judgment: Compliant

Regulation 7: Positive behavioural support

Not all residents who required one had a behaviour support plan in place. As a result staff did not have up-to-date knowledge to respond, and to support residents to manage their behaviour. Management had requested support in this area. Management demonstrated a commitment to promoting a restraint-free environment.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had systems in place to protect residents from all forms of abuse. Safeguarding plans were regularly reviewed. However it was noted that not all measures outlined in the plans were in place in the centre. All staff had completed training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Since the last inspection, the provider had taken steps to promote knowledge and awareness of residents' rights in the centre. Information regarding rights was on display throughout the centre, staff and management had completed training in human rights and consent, and human rights were discussed at every team meeting. Management also spoke with inspectors of their plans to reappoint advocacy champions in the centre. However, matters identified in previous inspections persisted. These included that residents' access to the kitchen area was restricted at times of reduced staffing, and the lack of private areas for residents to seek privacy and time alone, if they so wished, in some of the houses.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 7 OSV-0003297

Inspection ID: MON-0030113

Date of inspection: 09/02/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The staffing roster has been reviewed by the Person in Charge to include the activity coordinators and times which they are on duty. Staffing rosters are planned and staff rosters will show staff on duty day and night. Completed on 13.02.2023. • A review of the current whole time equivalent funded staffing number will be undertaken by the HR department and PPIM to ensure staffing numbers including nursing support are in line with the statement of purpose and assessed needs of the residents. To be completed by 30.06.2023. • PPIM will attend monthly meetings with HR department to escalate staffing vacancies and plan to fill vacancies in the designated centre.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Adverse incidents will be discussed at joint regional meetings and quarterly safety meetings. This will continue to provide oversight of incidents and notifications to HIQA. To be completed at next regional meeting 28.03.2023 • Regular management / regional meetings are scheduled with Person in Charge and PPIM to ensure effective management and governance oversight. Next scheduled meeting 28.03.2023 • Retrospective notification NF06 submitted by PIC (09.02.2023) on date of inspection. • To ensure effective delivery of care and support in accordance with the statement of purpose, a review of current staffing skill mix and resources will be undertaken. Following review and if required a business case will be submitted to the HSE requesting funding for additional resources. To be completed by 30.06.2023 • Management systems in the designated centre will be regularly audited to ensure services are safe and appropriate to resident's needs. Quarterly safety meetings will	

identify any adverse safety concerns. To be completed by 1.6.2023
• At the last HIQA inspection 29 residents resided in the designated centre. On date of the latest inspection, 25 residents resided in the centre. There is also a planned transition for one resident to another designated centre which is to be completed by 31.05.2023.
• A reconfiguration of the designated centre will occur to better support residents with the current staffing resource and skill mix. To be completed by 30.06.2023
• A number of factors have impacted the provider from achieving its original decongregation goals and timeframes for 2021, 2022 and 2023. These include but is not limited to, appropriate and available community-based homes on the open market and more recently the prioritization of a different designated centre for decongregation. The provider has revised the de-congregation plan for CCN 7 and has set new timeframes to achieve same. The provider continues to aims to complete decongregation of CCN7 by middle - end of 2025.
• The provider established a decongregation strategy group in January 2023. This group meets regularly to oversee the progression of decongregation plans across the organization and work progressively to achieve same. The decongregation of CCN7 is part of this strategy groups agenda. The providers decongregation strategy plan was submitted to HIQA at the end of January 2023.
• A transition coordinator has recommenced work in CCN7 early in 2023.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• A retrospective notification was submitted on date of inspector requested by inspector. Completed on date of inspection 9.02.2023.
• The PIC will ensure notifications of any allegation suspected or confirmed, of abuse of any resident will be submitted to HIQA within three working days.
• The restrictive practice log will be updated to include a locked press in the bathroom. Completed on 28.02.2023.
• The quarterly returns will include each occasion an environmental restriction is recorded. To be completed in next quarterly return 30.04.23.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• Consent for money paid into a nominee account was obtained a number of years previously. A residential forum meeting will be held and a social story regarding residents' money will be developed to support understanding and request consent. To be completed by 30.06.2023.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• The activity co-ordinators will review community activities and develop a plan based on

each individual residents' preference. To be completed by 30.06.2023. • An Advocacy Champion has also been identified which will further support choice making and consent in CCN7. • Each resident has a key worker that will support links and relationships with the wider community.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A review of the premises by the Person in Charge /Facilities manager and contract cleaner to take place. A schedule of deep cleaning to be completed by 10.04.23. Deep clean to be completed by 30.04.2023. • The Facilities manager will schedule a walkthrough of the premises to identify any works required in CCN7. Schedule 6 will be considered as part of the walkthrough. To be completed 30.04.2023.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • Damaged surfaces have been identified for repair and submitted through the maintenance system PEMAC. To be completed by 31.05.2023. • Contingency plan submitted by PIC to HIQA following inspection.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • Prescriptions will be audited to reflect any changes to dosages of medication. • The organisations medication management policy is currently being reviewed regarding residents PRN protocols. To be completed by 30.04.2023	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • The provider, in sofar as reasonably practiable, will support residents who require a quiet and calm environment and support residents with rerquirements of transitioning in line with their assessed needs. • Each resident will have an updated oral assessment completed and referred to the dentist . To be completed by 31.05.2023. • Each personal plan will be reviewed and assessed needs will be identified where additional supports are required . If necessary a business case will be submiited to the HSE for additional resources. To be completed by 30.06.2023. • No new admisions have been accepted into CCN7.	

• An auditing schedule and action plan will be developed by the PIC to review monthly progress goals. First audit and action plan to be completed by 30.4.2023 • A review and update of all personal plans to be completed by 30.06.2023

Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • A CASS referral was sent in December 2022 for positive behavior support for one individual. A response was received with a commencement timeframe of three months. A review has commenced and this will be completed by the ANP in Positive Behavior Support. To be completed by 30.04.2023.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • All measures outlined in safeguarding plans will be made available for staff in each residence within the designated centre. To be completed by 30.04.2023	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • All restrictive practices will be included in quarterly reports. The restrictive practice of door locking will be timed and logged and submitted in quarterly returns. To be included in next quarterly returns 30.04.2023.	

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 12(4)(a)	The registered provider shall ensure that he or she, or any staff member, shall not pay money belonging to any resident into an account held in a financial institution unless the consent of the person has been obtained.	Substantially Compliant	Yellow	30/06/2023
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.	Substantially Compliant	Yellow	30/06/2023
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and	Substantially Compliant	Yellow	30/06/2023

	maintain personal relationships and links with the wider community in accordance with 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	30/06/2023
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	30/06/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	20/03/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	30/04/2023

	state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/04/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2023
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	30/06/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/06/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are	Substantially Compliant	Yellow	31/05/2023

	protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	30/04/2023
Regulation 31(1)(d)	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 serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	09/02/2023

Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	09/02/2023
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	30/04/2023
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	30/06/2023
Regulation 05(3)	The person in	Not Compliant	Orange	30/06/2023

	charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/06/2023
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/06/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to	Substantially Compliant	Yellow	30/04/2023

	support residents to manage their behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/04/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	30/04/2023