Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City South 1
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	13 October 2021
Centre ID:	OSV-0003695
Fieldwork ID:	MON-0034542

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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
Wednesday 13 October 2021	11:00hrs to 18:30hrs	Lucia Power	Lead
Wednesday 13 October 2021	11:00hrs to 18:30hrs	Aoife Healy	Support

What residents told us and what inspectors observed

On the day of the inspection, the inspectors met with a number of residents in each of the three houses. Upon arrival at the first house, inspectors were introduced to the residents and following this one resident brought inspectors on a walk around. The resident showed inspectors their bedroom which were observed to be personalised to the residents choice. The resident showed inspectors photos that were displayed in their bedroom of their family and of trips that they have been on. This resident also chatted to inspectors about where they were from and where they were born and asked inspectors a little about themselves also. Inspectors had the opportunity to speak with residents and to ask them if they liked living in their home. Residents told inspectors that they did like living in their home. One resident told inspectors that they like going out for walks and spins around Cork and that they were going on a spin into the city that afternoon. Inspectors heard from residents about how they know to speak to their 'house father' if they are worried about something. However, even though some residents highlighted they liked living in their home, it was noted in this house that resident's had made complaints in relation to another resident and that they did not like living with this resident. From a review of the records in this house it was noted that residents were subjected to shouting and had to leave the breakfast room due to this resident instructing them. This is discussed in the quality and safety section of this report.

In the second house that inspectors visited on that day, residents were observed to be engaging in activities such as making cards and other art work. Inspectors were introduced by the staff, to the residents. Inspectors asked residents if they would like to speak with them in the living room. Four residents came to talk with inspectors, while one resident continued with their art work. When asked if residents liked living in their home, all agreed that they did and one resident said that they felt safe in their home. One resident said that they missed their day service. Residents told inspectors that they enjoyed going walking together and that they used to do this during COVID-19 restrictions because they couldn't go to other places that they would have liked. One resident told us how they like to go grocery shopping and that they do this with another resident. One resident told us that sometimes it is difficult living with other people in the same house, but that for the most part they get on well. Inspectors were told by staff that one resident was going home to visit family at the weekend and that they really looked forward to this, to which the resident smiled in agreement.

In the third house, inspectors observed staff and residents engaging in conversation on arrival. Inspectors were informed that residents were just back from day services and they were telling staff about their day. One resident told inspectors that they had a good day and that they were busy doing art and knitting at their day service. Residents offered inspectors a cup of tea and were keen to talk to inspectors about where they were from.

The next two sections of the report present the findings of this inspection in relation

to the governance and management in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This inspection was an unannounced risk based inspection. From the findings on this inspection it was evident that the registered provider did not ensure effective oversight and governance of this designated centre. There was a lack of management presence in this centre from the registered provider. Given ongoing issues raised by the Person in Charge (PIC) and findings from the registered providers own internal audits, the registered provider had failed to respond effectively and appropriately.

This section of the report will demonstrate the impact in relation to the regulatory non compliances and failings due to poor governance and management.

Staffing was reviewed as there are a number of residents with complex and changing needs. It was evident by observation and discussion that staff were very supportive and attentive to resident's needs, staff also had a very good knowledge of each resident and were able to discuss current issues and changing needs presenting for the resident. However, staff had to streamline their focus to more task focused activities as there were insufficient staff to support the personal and social assessed needs of residents.

The person in charge told the inspectors that there was a shortage of skill mix in the centre and it was also noted that staffing numbers were not in line with the provider's statement of purpose. From a review of documentation it was cited through risk assessments and capability assessments of the requirement to have 2:1 staffing for some residents. From a review of the roster this was not evident and the provider did not have in place the recommended staffing to meet resident's needs. It was also noted that for one of the houses, the rota did not include the staffing for the morning and afternoon period. This information is important under the regulations as the provider is to ensure that the skill mix of staff is appropriate to the residents needs. It is also required that the person in charge ensures that the planned and actual rota shows staff on duty during the day and night.

Annual reviews and provider unannounced visits form part of the monitoring systems in the operation of a designated centre. It is the providers responsibility to ensure these are carried out to ensure the quality and safety of services and care and welfare of residents is maintained. The registered providers annual review was carried out in April 2021 and this review highlighted issues in relation to governance and management. It also referenced that the person in charge could not ensure effective oversight given the current levels of responsibility and also fulfilling the role of PIC for other designated centres. This annual review did not include the views of

residents but the registered provider had consulted with residents' representatives who cited "staff are professional and caring and have a personal approach", "improvements to the garden and more seating is required". It was also highlighted in the review that a representative cited "COPE's management communication is sporadic and poor". An action plan was in place but there was no evidence of follow up in relation to the actions and no follow up from the registered provider in relation to the issues highlighted regarding governance and management. There was also no evidence to demonstrate that management had visited the centre in over a year, this was also flagged by the person in charge and staff. Prior to this inspection the provider had carried out an audit on the 07 October 2021 and this was made available after the inspection. This audit also reflected issues in relation to the governance and management and the impact on the PIC who was covering gaps in the roster on an ongoing basis.

The person in charge is to ensure that staff have access to training and supervision. The training records were not clear on the day of inspection and there were gaps noted. The provider was requested to submit these records the day after the inspection, however, these was not submitted until over a week after the inspection. There was no evidence that supervision was in place for staff. Both the PIC and staff told the inspectors that supervision was not happening. There was some evidence that the PIC received supervision. These notes identified that the PIC requested support on a number of occasions, flagging their concerns that that were unable to carry out the function of the role due to lack of governance and support.

Prior to the inspection it was evident that notifications were submitted outside the regulatory time frame to the Health Information and Quality Authority (HIQA). Under regulation 31, the person in charge is to give the chief inspector notice in writing within 3 working days following an adverse incident in the designated centre. From a review of the residents daily notes, the inspectors noted that incidents occurred in the centre in July 2021 and these had not notified to HIQA. There were 7 in total from review that required a NF06. This is a notification relating to any allegation, suspected or confirmed abuse of a resident.

The provider had an updated statement of purpose in place. The inspectors had a version No.14, but on the day of inspection a version No. 17 was made available. After the inspection the provider advised that a version no. 15 had been sent to HIQA in April 2021. However, there was a variance between version No. 15 and No. 17 presented to the inspectors. It was observed on the day of inspection that a registered bedroom, specifically for residents' with mobility issues, was being used as a staff room. Under schedule 1 of the regulations the provider is required to include information in the statement of purpose that outlines the specific care and support needs and a description of the rooms. On the day of inspection the registered providers statement of purpose did not accurately reflect the operation of, nor the designated rooms previously outlined to HIQA.

Regulation 15: Staffing

The registered provider did not ensure that sufficient staffing was in place in line with the residents assessed needs. Assessments carried out identified the need for 2:1 for some residents, it was noted that this resource was not in place for some residents. It was also noted that the rota did not contain staff on duty during the day for one unit and only referred to night duty.

Judgment: Not compliant

Regulation 16: Training and staff development

Training records on the day of inspection reflected a number of gaps.The provider was requested to submit the training records to the inspectors the day after the inspection. However, a follow up call had to be made to secure the records previously requested. Records were provided for 26 staff. These records were incomplete. From the records provided, it was identified that less than a third of the staff team had up-to-date training in safeguarding and in the management of behaviour that is challenging including de-escalation and intervention techniques. Less than half of the team had up-to-date training in fire safety. These trainings are required by the regulations.Staff did not have access to appropriate supervision and this was evident on the day of inspection. Staff also told the inspectors that they wanted to avail of supervision but did not this support.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had a directory of residents in place in the designed centre. This was noted to contain the information as set out in schedule 3

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not ensure effective oversight of this designated centre. The annual review and six monthly audits had identified issues with the centre and particularly in relation to governance and management. There was no evidence that the provider followed up on their own findings to ensure the care and welfare and the quality and safety of the services to residents was been effectively monitored. The person in charge was covering a number of gaps in the designated centres roster due to cover staffing absences as well as managing another designated centre. The requirements of regulation 14 were not met demonstrated by ineffective governance impacting on the operational management and administration of the designated centre. There was significant slippage in this designated centre from the last HIQA inspection in August 2019 when at that time the provider had demonstrated a good level of compliance.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had on admission agreed with a number of residents the terms in which they would reside in the designated centre. However, there was no contracts in place for two residents who resided in the centre from early 2021.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider did have a statement of purpose in place in the designated centre. However not all information was accurately reflected in relation to schedule 1 of the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge did not notify the Chief Inspector within 3 working days of adverse incidents which had occurred in the designated centre.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a complaint procedure in place in the designated centre and it was noted that this was been kept up to date and the complainants informed of the outcome of their complaint.

Judgment: Compliant

Quality and safety

The inspectors found that improvements are required by the registered provider to ensure that effective oversight is in place in relation to the quality and safety and care and welfare of residents. The provider did not demonstrate effective management and oversight of this centre and it was evidenced that there was significant levels of non compliance since the last inspection carried out in August 2019.

The provider was found to be complaint in regulation 5, regulation 8 and regulation 9 on the previous inspection. However findings on this inspection found these three regulations to be not compliant which demonstrated slippage in relation to the quality of the lived experience for residents.

From the files reviewed on the day of inspection it was noted that monthly key worker meetings, identified by the registered provider, were not been carried out with residents. In one of the files there was no update for three consecutive months. There was also no evidence of goals been reviewed for a number of residents and the residents' wishes in relation to social activities was not incorporated in their plans. For example, one residents goals were to make tea, have a pamper session and buy something nice. These goals were task focused in nature and there was no evidence to show that these had been explored with the resident. For another resident it was highlighted to plan a party for a significant birthday. However, the birthday was six months previously and there was no evidence of follow up. This goal remained outstanding. It was also noted on inspection that not all residents' had a yearly planning meeting as required by regulation. There was no evidence demonstrating a forthcoming date for such meetings.

It was noted that residents logged complaints pertaining to another resident and the impact on their lives. For example, it was noted that a resident was continuously calling their peers, shouting, standing behind them while at breakfast and shouting instructions at them. Residents also told the provider that they no longer wanted to live with a particular resident. Staff informed the inspectors that the weekend prior to the inspection, this resident had struck other residents. This allegedly happened

on a Saturday and Sunday. There was no evidence of these behaviours been monitored or guidance given to staff. There was evidence on file that a referral had been made for behavioural support and evidence that staff had emailed the person in charge on a number of occasions seeking support. A family member had also queried behavioural support for a resident and was informed the resident was on a list. Given the impact to other residents', the registered provider did not demonstrate any actions to mitigate the risk for residents' nor support to the resident exhibiting the behaviours. There was no safeguarding plans in place for the residents' impacted and the provider did not notify HIQA in relation to a number of the peer to peer incidents. There was no evidence of action taken by the registered provider in relation to the rights of residents when it was highlighted they no longer wanted to live with a particular resident. It was noted that residents' had to leave the breakfast room due to their peer shouting and throwing a cup and jug at them.

Regulation 17: Premises

The registered provider ensured that the centre was laid out to meet the needs of residents, it was clean and homely. However, there were some repairs required to kitchen units. It was also noted that that a front garden required maintenance. This had also been highlighted by a family member in the registered providers audit.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a current risk policy in place and risks were identified. However, not all risk assessments were updated in line with the registered providers own review dates.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Based on observations during the inspection, staff were adhering to good infection control practices. However, in one of the houses, the registered provider did not

have an infection control contingency plan in place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The registered provider did not ensure the residents plan was subject to a review carried out annually or frequently in line with the residents changing needs. On the day of inspection it was noted that not all residents had a planning meeting and their goals were not been reviewed. There was also a lack of follow up with residents in relation to goals identified.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had comprehensive healthcare plans in place for residents and there was good follow up with healthcare professionals. Staff demonstrated a very good knowledge of residents health care needs and it was evident that good supports were been given to residents with recent medical diagnoses.

Judgment: Compliant

Regulation 7: Positive behavioural support

From records reviewed it was evident that supports were required in relation to behaviours that challenge. Despite attempts by staff to get support in relation to guidance, there were no measures taken by the registered provider to provide such supports to ensure that staff could respond appropriately.

Judgment: Not compliant

Regulation 8: Protection

Residents had reported the impact that another resident was having on their lives, there were no safeguarding plans evident on the day of inspection for these residents. The provider did not demonstrate that residents were assisted to develop the knowledge, self awareness, understanding and skills needed for self protection.

The provider did not have a plan in place to demonstrate that they were taking actions to support residents to be safe.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider did not ensure that each residents privacy and dignity was respected. Residents had highlighted their concerns in sharing a living space with another peer and the impact this was having on their lives. They had highlighted a number of times that they did not want to live with a particular resident. There was no evidence to demonstrate what actions were taken by the provider based on the views of the residents.

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 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City South 1 OSV-0003695

Inspection ID: MON-0034542

Date of inspection: 13/10/2021

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 PIC, PPIM and allocations officer will meet to review the skill mix and the WTE for CCS1. The Registered provider will make every effort to ensure that WTE, qualifications and skill mix is appropriate to the assessed needs of the residents and in line with the SOP.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person In Charge will put a training plan in place and will link with the trainers to establish an appropriate time frame for the training to be completed. All staff have been requested and committed to complete online safeguarding vulnerable adults training. The PPIM will meet with the PIC weekly and visit Cork City South 1 monthly. The registered provider will ensure that members of staff are aware who they can link in with if PIC is not available furthermore, in consultation with all staff they will be made aware they can request 1;1 supervision through the PIC or PPIM at any point, outside of their 1;1 Performance Management Review meeting.	

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 assess the resident's needs and develop a plan to ensure the resources are available to support effective delivery of care and support in accordance with the statement of purpose. The Registered provider shall make every effort to ensure that management systems are in place to ensure that the service provided is safe, appropriate to resident's needs, consistent and effectively monitored.
The PIC who is supported by PPIM are in place working across the week with on call support out of hours and throughout the night.

In response to the regulatory non-compliance that was identified by the providers audit, this is being actioned by the Registered Provider. The PPIM has committed to maintaining daily contact with the PIC via email/phone and on a weekly basis face to face. The Pic and PPIM will schedule weekly meetings to ensure oversight and monitoring of the Centre.
Annual reviews and six monthly audits will be an agenda item for the PIC and PPIM monthly meetings

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The Registered Provider will ensure that a contract of care will be completed for all individuals living in CCS1 and furthermore, ensure that any new admissions to CCS1 will also have a contract of care.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Registered Provider has reviewed the SOP and the floor plans that are currently being edited to accurately reflect the current operation of the designated centre.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC/PPIM will ensure that all notifications in relation to adverse incidents, any allegation, suspected or confirmed abuse of any resident that had occurred in the designated centre are reported in a timely manner (within 3 working days).

The registered provider will ensure that the 2 notifications are reported retrospectively by 1st December 2021.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider shall ensure that the premises of the designated center are of sound construction and kept in a good state of repair externally and internally. Facility manager will be requested to carry out a walk through CCS1 with the PIC and agree works that need to be completed.

Furthermore, PPIMs and facility manager meet monthly to identify, prioritise and agree together a plan of works in relation to larger works that also may need to be completed.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk register will be reviewed by the PIC and updated to reflect current risks.

Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: The PIC shall review all residences in CCS1 and ensure infection control contingency plans are in place by the 19/11/2021	
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 PIC shall review all personal plans and update, furthermore a schedule will be developed for further reviews throughout 2022. Personal plans will be audited in relation to their effectiveness on a 3 monthly basis.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The Person in charge shall ensure that all residents behavioural support plans are reviewed with the behavioural support team and the staff team supporting the residents. PBS training shall be arranged for all staff in line with the training and staff development plan by the 17th January 2022. The Registered provider in consultation with the residents shall make an application for therapeutic supports if required by the residents through CASS referral system by 15th December 2021.	
Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: The PIC shall ensure that all safeguarding plans are completed in relation to any alleged issues of concerns. All interim safeguarding plans will be shared with staff members and the person allegedly being abused and where they will be supported to develop the knowledge and skills needed for self-protection. All staff have been requested and committed to complete online safeguarding vulnerable adults training. PPIM and Designated Officer have had discussions in relation to members of the team being trained up in how to complete Preliminary Screening Forms and developing interim safeguarding plans.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The staff are familiar with the wishes and preferences of the residents and are committed to always supporting their rights. However, the Registered Provider will explore the current skill mix and perhaps identify a member of staff to focus on Advocacy to support the residents with their concerns, this may include some advocacy training. The PIC shall audit Advocacy meetings and put a plan in place for more regular meetings with the residents where every resident can be listened too and where the residents can discuss issues that maybe arising and with support explore how their home can be a happy living home. The registered provider has requested PBS supports to reengage with the person allegedly causing concern and put a plan in place to support all residents and members of staff 29/11/2021.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/01/2022
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	30/01/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the	Not Compliant	Orange	30/11/2021

	day and night and that it is properly maintained.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/01/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/11/2021
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	20/12/2021
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	30/12/2021
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the	Not Compliant	Orange	30/11/2021

	designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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	30/11/2021
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	01/11/2021
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	Not Compliant	Orange	31/01/2022

	safety of the services that they are delivering.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	01/11/2021
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	14/12/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/12/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare	Substantially Compliant	Yellow	19/11/2021

	associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/11/2021
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	14/10/2021
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	Not Compliant	Orange	14/10/2021

	abuse of any resident.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	30/01/2022
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.	Not Compliant	Orange	30/01/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out	Not Compliant	Orange	30/01/2022

	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.			
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 support residents to manage their behaviour.	Not Compliant	Orange	17/01/2022
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	31/01/2022
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for	Not Compliant	Orange	30/01/2022

	self-care and protection.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	01/11/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/01/2022