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:	Bantry Residential
Name of provider:	CoAction West Cork CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	09 and 10 November 2023
Centre ID:	OSV-0002105
Fieldwork ID:	MON-0038675

About the designated centre

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

This designated centre consists of four houses in a rural town setting. Each of the houses contain a kitchen, sitting room, single bedrooms, bathroom facilities and outdoor areas and gardens. The centre provides residential and respite services for up to 17 people, aged over 18 years. Residents are both male and female, with a diagnosis of intellectual disability. Staff support is provided by social care workers / leaders and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 November 2023	10:00hrs to 19:00hrs	Lucia Power	Lead
Friday 10 November 2023	10:00hrs to 13:30hrs	Lucia Power	Lead

What residents told us and what inspectors observed

This was a follow up inspection to review the provider's compliance with the regulations. The inspector found that residents were safe and that staff supporting them did so in a caring and dignified manner, however improvements were required in relation to living conditions, rights, assessed needs and the provider's monitoring of the centre.

Bantry Residential comprises four units and is registered to accommodate 17 residents. Residents in this centre were supported to be active in their community and availed of the provider's day services in the community. Some residents would like more opportunities to realise their goals but told the inspector there was not enough staff. However, residents did tell the inspector that staff supporting them were very kind and always listen to them. However, some residents did not like their home and were looking forward to living in another house.

This inspection was carried out to ensure that the actions the provider committed to in their compliance plan response from the inspection carried out on behalf of the Chief Inspector in June 2022 were implemented, particularly actions in relation to staffing, governance and management, premises, individual assessment and personal plans.

When the inspector arrived to the first house all the residents with the exception of one were attending their day service. The resident at home was resting so the inspector took the opportunity to walk around the building. From point of entry it was noted that the main door to the house was locked and this was not accessible for residents. Personal information relating to the residents was seen in the utility room and was not in a secure place. This was also noted within other houses of the designated centre, with information about residents in kitchen areas, utility rooms and sitting room areas.

The utility room in the first house was unkempt and storage of food under the sink area was overloaded and goods fell out when the inspector opened this door. The kitchen area was notably dirty and there were peas and dirt lodged between the flooring and the cupboards. This appeared to have been built up from a period of time. The kitchen units were distressed and worn looking, there was also a build-up of what to appeared to be oxidising substance around the knobs of an unused cooker.

The main bathroom and only bathroom in this house was seen to have a rusty shower holder and there was rust evident on the support mechanism for the toilet. Mould was also noted in a cupboard upstairs and in the bathroom. The rooms as defined in the provider’s floor plan were found to vary on the day of inspection, for example a room designated as a bedroom was used as a storage area for wheelchairs and a bag of potatoes was also noted to be stored there.

The first floor of this house accommodated two residents. There was a toilet facility at the end of the hallway and a built-in shower that was not in use with a sign noting "not to use the shower ever". The light into this room did also not work adequately. The inspector queried how the two residents in this section of the house utilised the bathroom and was advised that they used the one downstairs. This was not supportive of the assessed needs of the residents and their current presentation.

The floors in the hallway were dirty and the building lacked a homely environment as furniture, walls, and overall general appearance was evidently worn. The house was also cold.

The inspector walked around the outside of the house and noted a significant amount of moss on the roof and on the concrete ground where it had fallen off the roof over a period of time. The paving was uneven and there was drop-down step at the side of the house which may impede mobility for residents.

On the second day of the inspection the inspector visited the three other houses and noted that two were well-maintained however one required some work. Flooring in one of the resident's bedrooms required attention as the timber was lifting and this could impact the current assessed needs of the resident using this room. There was plaster missing from some of the areas around the doors and an electrical cord protruding from the wall behind the door.

There were also issues noted with fire doors on both days of inspection as the doors did not close properly. It was also noted that a couch in the sitting room area blocked an exit which was a fire door and the double doors in this room were very difficult to close which could impede the safe evacuation of residents.

From the inspector's observations it was noted that staff interactions with residents were very person-centred and caring. It was seen that staff approaches did respect the individual needs of residents and they were very direct in telling the inspector that there were insufficient supports to deliver a service that met the assessed needs of the residents.

The inspector did observe the support needs of residents and it was noted in one of the houses that three staff were supporting three different residents with their dinner while two residents were watching television. In one of the other houses it was noted that a staff member was supporting a resident with high needs and this resident due to their diagnosis vocalised and could become quite aggressive with the staff member. The staff member was very calm, supportive, and responsive to the needs of this resident and it was evident had a very good understanding of the resident's needs.

From speaking with staff, there was a concern that they could not deliver services appropriate to the residents' needs due to staff resources. When asked about the safe evacuation of residents in the event of a fire, staff did not feel competent with the current resources and changing needs of residents that they could facilitate this. Further reference to this will be made in the next section of the report.

The inspector met with six residents over the two days of this inspection and spent

some time talking with them.

One resident told the inspector that the house was cold and they did not like living there. They did highlight that the provider was looking for a new house but did not know when this would happen. A resident also told the inspector that having to share the bathroom with others was very difficult and described to the inspector how it was hard to wait to go to the bathroom when someone else was being showered as it was a long wait. The resident also told the inspector that they were to have a lie in three times a week and this could not be supported due to lack of staff. They also said they would like to do more activities, like go to mass, but they don't ask as they know staff are under pressure.

Another resident told the inspector that they were looking forward to moving to another house and went on to tell the inspector about the colour of the room and type of flooring they want. Overall the residents did tell the inspector that staff were very kind and supportive to them and that they were happy with the staff.

The next two sections of report will highlight areas required for improvement in the capacity and capability and quality and safety for residents.

Capacity and capability

The provider needed to ensure greater oversight in relation to the monitoring of the centre to ensure quality and safety in the care and welfare of residents. Improvements were required in staffing, governance and management, premises, individualised assessment and personal plans, and rights of residents.

This inspection was carried out to review the compliance plan response the provider submitted post the June 2022 inspection, and also to validate the provider's response in relation to the actions carried out in the interim as outlined in an update provided to the chief inspector in November 2022. One of the key findings of the inspection was an issue with premises. The chief inspector had afforded the provider an opportunity to follow up on this action and also time in relation to a governance and management organisation restructure.

The inspector noted that the statement of purpose that was in the designed centre did not contain all the information as required by the regulations. The management structure was incorrect and there were areas that required updating. The provider was affording time while the inspector was there to rectify the statement of purpose. This was reviewed and another statement of purpose was updated. However this too did not contain the information as required, for example the registration details were incorrect.

The inspector advised the provider that due to some of the initial findings, for example regarding premises, staffing, and governance and management, that the inspection was now a risk-based inspection and would be completed over a two-day

period.

The provider had committed to coming into compliance with the regulations by the 31/03/23 and in an updated compliance plan to the chief inspector had provided confirmation that some of these actions were completed. This was not the finding on the days of this inspection and the provider was issued with three urgent actions regarding Regulations 23 Governance and management, 17 Premises, and 28 Fire precautions.

The provider had in place a person in charge who consisted of two staff making up one whole time equivalent. It was evident on the day of inspection that the person in charge was committed to improvement and compliance. However due to staff shortages they were covering a number of the shifts and were unable to ensure the effective governance, both operational and administrative, of the designated centre. It was evident that they had a good understanding of the residents and were committed to delivering a good service but this was impacted due to the inability to oversee the services. This finding will be actioned under governance and management.

The provider had carried out the annual review and six-monthly audits, however there was no evidence to support that reviews and implementation of the actions outlined in these reports had taken place.

The provider was having meetings with the persons in charge for all their registered centres, however there was a lack of oversight in relation to the centre given the findings on the day of inspection, such as state of the residents' home, residents' files, individualised assessments and plans, and the rights of residents.

It is acknowledged by the inspector that staff shortages remain an issue for the provider and they have tried a number of recruitment initiatives. The provider also outlined this deficit on their risk register. However on the days of inspection it was noted that staffing was not in line with the statement of purpose and did not reflect the number and skill mix of staff as outlined in this document. The statement of purpose forms part of the conditions of registration of the centre.

The person in charge had submitted a proposal to the provider in August 2023 seeking an assessment of need for each resident as the staffing levels were not deemed adequate for their current needs. At the time of inspection the person in charge had not received a response. The inspector also requested this from the provider but there was no evidence made available to demonstrate a response was sent.

Regulation 15: Staffing

The provider had made efforts to recruit additional staff but have found this a struggle. However the number, qualifications and skill mix of staff appropriate to the

assessed needs of residents were not in place on the days of this inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not demonstrate effective governance of the designated centre and a number of improvements were required.

- The provider did not ensure the effective delivery of service in accordance with the statement of purpose as the staffing allocated in this statement of purpose did not accurately reflect what was found on inspection. For example, the skill mix was not reflective of the current rota and the social care leader post for two of the units was also the person in charge.
- The provider did not have a clear, defined management structure in place and also the statement of purpose did not accurately reflect the organisational structure.
- There was an absence of management structure from the provider and this was evident from the findings on inspection. For example, there was no follow through in relation to person in charge requests, appropriate supervision for the person in charge, and oversight of the action plan arising from the annual review and provider's own unannounced inspections.
- The provider also had not ensured they were in compliance with the regulations and the commitment they made to the chief inspector, post the June 2022 inspection. As noted previously the findings on this inspection did not reflect the update from the provider which was submitted in November 2022.
- Given the findings on this inspection and the state of neglect within some of the houses the provider did not ensure the care and support and quality and safety for residents.
- Given these findings the provider was issued with an urgent action in relation to Regulation 23 Governance and management.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose available on inspection did not reflect the management structure in place in the centre. It was also not updated within the one year period. The inspector afforded the provider time to update this accurately, but the next version did not have the current registration details.

Judgment: Not compliant

Quality and safety

The provider did not ensure the quality and safety of each resident and due to their current living environment in one of the houses and insufficient resources, this had an impact on the lived experience for residents.

Residents in one of the houses expressed that they were cold and they did not like their house. The provider had committed to ensuring the residents would be accommodated in a house that suited their assessed needs. At the time of the inspection it was noted that the provider had engaged with another organisation to review another house. On the day of inspection a report was given to the inspector that this house was now not suitable and could only accommodate two residents. There was no contingency plan in place nor was the current accommodation for these residents fit for purpose. As highlighted previously in the report, the house was cold, not accessible to meet the changing needs of residents, the external area was a potential risk, and the internal area was distressed, worn and unkempt. The inspector asked if an assessment was carried out in relation to a resident with changing needs whose bedroom was on the first floor. This assessment was carried out by a health and social care professional. The findings noted related to the resident having to adjust to the environmental layout, for example not encouraging the resident to go upstairs as regularly and to wear another type of shoe wear.

Individualised assessments and personal plans were reviewed in two of the four houses. In one of the houses the plans were not reviewed in line with the timelines, goals were not meaningful and task focused for example, maintain good health, go for a drive, and go to the shop. There was also a lack of review and goals had not been reviewed in a consistent manner in line with the provider's own process. However in one of the other houses a personal plan was well documented with good follow up and outcomes. Due to staffing issues not all residents could be supported with their goals and residents told the inspector of their frustration in relation to this, for example a resident had to go to the day centre when they wanted a lie-in as there was no staff. This was part of the resident's plan but could not be facilitated.

Over the two days of inspection the inspector noted that fire doors did not close correctly. This was highlighted and demonstrated to the person in charge on the day of inspection. A sofa used by residents was blocking a fire door which impacted the route if evacuation was required. The double doors into this room were stiff and difficult to close. The inspector reviewed the fire drills carried out by the provider and noted it did not state the number of residents or staff at the time of the fire drill or if it was a day/night simulation. From review of the residents' personal evacuation plans the supports required were not in line with the staffing on duty. Staff told the inspector they would not be confident that they could fully evacuate the residents

with the current staffing supports.

The provider had very good systems in place to support the healthcare needs of residents. There was good evidence of linkage with health and social care professionals and health care plans were in place to support the needs of the residents.

Overall the quality of service delivered to residents was impacted by their current environment and insufficient staff.

Regulation 17: Premises

The registered provider had not ensured the premises were laid out to meet the assessed needs of residents.

- There was evidence of poor state of repair internally and externally.
- One of the units was unclean, cold, and not homely to suit the residents' needs.
- There was evidence of dirt, uneven flooring, rust, plaster coming off the walls, mould and rusty objects.
- The registered provider did not meet the requirements as outlined in Schedule 6 of the regulations.

The provider was issued with an urgent action pertaining to Regulation 17 Premises.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider did not ensure that effective fire safety management systems were in place in the designated centre.

- During the inspection it was noted that a number of fire doors did not close properly and this was pointed out to the person in charge.
- There was also a sofa seen to block an access route which impacted safe evacuation as the double doors were difficult to close.
- The inspector sought assurance from the provider pertaining to a toilet that was under the stairs. This formed part of an inner room that was also used as a utility room which had a washing machine and drier.
- From a review of the residents' personal evacuation plans there was a requirement for a higher level of staff support than what was available at night time.
- The provider had not ensured that a simulated night time drill had taken place to truly reflect the assessed needs of residents.

- Also some plans were not updated to reflect the changing needs of residents. From speaking with staff in one of the units they told the inspector they could not evacuate the residents given the number of staff and needs of the residents.

The provider was requested to review this as a matter of priority and an urgent action was issue pertaining to Regulation 28 Fire precautions.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge did not ensure that personal plans were subject to a review, carried out annually and reviewed in line with changing circumstances.

- Personal plans were not updated to reflect the residents' personal goals.
- There were delays in relation to planning meetings and also no follow through in some of the goals.
- The goals were repeated for some years and were not meaningful to support the expressed wished of residents.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had appropriate healthcare in place for residents and this was demonstrated in the healthcare plans which reflected updates to support the residents' healthcare needs. There was good follow up and ongoing reviews pertaining to residents and their changing needs.

Judgment: Compliant

Regulation 8: Protection

The registered provider had systems in place to protect residents from abuse. Safeguarding plans were updated and reviewed.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had not ensured that residents rights were respected.

- On the day of inspection residents' information was noted to be in communal areas and not secure.
- Some residents could not access community facilities due to staffing and were unable to realise some of their goals due to lack of resources.
- Residents within their home were not afforded privacy and dignity in relation to intimate and personal care due to the lack of bathroom facilities.

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 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Bantry Residential OSV-0002105

Inspection ID: MON-0038675

Date of inspection: 09/11/2023 and 10/11/2023

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: • HR is actively addressing our recruitment challenges as a primary focus to source suitably qualified and experienced candidates; and successfully fill our job vacancies within a timely manner. • The HR Department is currently exploring new and/or alternative sourcing methodologies. • The employee referral scheme payment has is currently under review, with a proposal to enhance payment due for decision in December.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • CoAction are reviewing their ability to provide respite within Bantry Residential in tandem with the resource across its other designated centres with a view to consolidate resources and ensuring the safe provision of services. Consultation with residents and their families or circles of support will be carried out in Q1 2024 • The Statement of purpose has been updated to accurately reflect the line management structure of the designated centre. A schedule for yearly review is implemented across the designated centre to ensure regular and reflective review of the statement of purpose to accurately reflect the designated centre. • Clear lines of reporting and responsibility have been identified and outlined in the structures guide, that is now available and specific to each house in the designated centre.	

• Clearly structured roles and responsibilities documents specific to each house in the designated centre are currently being reviewed with the PIC's and respective staff team. Following review these will be available in each house and to each member of the team by 19th January 2024.
• A live Action Tracker has been implemented to record and document the progresses of Annual Reviews, Inspection Actions and 6 Monthly Audits. This will be a working document across the designated centre.
• Monthly supervisions have been scheduled with the PIC's for Bantry residential for the next 12 months. A new PIC Supervision Template has been developed and notified to HIQA which will be used as a supportive document.
• Bi-Monthly PIC meetings are scheduled for the next year, these meetings are made up of all PIC's in the organization and will provide further peer support.
• PIC Registration of NF30A has not been submitted as noted in previous return on the 16/11/2023. This will be sent upon the return of reference forms and it is hoped to be submitted by the 22/12/23.
• The Assistant Director of Services (ADOS) has been placed in situ from the 4th of December 2023 and will be an additional governance oversight on the centre. An application to place the ADOS as a PPIM of Bantry Designated Centre will be put in by the 26/01/24.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of purpose has been updated to accurately reflect the line management structure of the designated centre and submitted on the 16/11/2023.
• The statement of purpose has been updated to reflect the current staffing within the designated centre and submitted on the 16/11/2023.
• A yearly schedule for review has been set with the next review date scheduled for 01/04/2024.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Works that have been completed since the inspection within the Designated Centre are as follows:
o A deep clean of two houses within designated centre has been arranged with professional cleaners. The deep cleans were completed in Slip Lawn on the 20th of November and in Seskin on the 24th of November. A contract is being sought with

professional cleaners to provide a schedule of regular professional cleaning for the next 12-month period the frequency of which will be decided in consultation with the cleaning company.
• Rusted bathroom appliance has been removed.
o External door lock to side door in Bayview Seskin has been replaced with thumb lock on the 20th of November.
o Couch in Slip Lawn has been removed.
o CoAction's maintenance team completed a walk around the designated centre on the 15th of November and have compiled a schedule of works to ensure ongoing maintenance and repair are completed on a prioritized basis. This included but was not limited to the issues identified during the inspection in both Slip Lawn and Seskin. A quarterly walk around the designated centre is scheduled with the maintenance team, to ensure ongoing review and prioritization of repair and maintenance.
• In Bayview Seskin the pathways and steps externally are being reviewed with contractor to identify how to make them accessible to all residents in the home. This is currently pending planning with the project manager.
• A competent person has been requested to review the possibility of making the second toilet on the ground floor accessible to ensure residents do not need to wait for the bathroom if the other bathroom is occupied. Contract review property is currently being conducted and considered.
• A competent person has also been requested to review the upstairs bathroom facilities, to establish the feasibility of re-commissioning it. Contractor's review of property is currently being conducted and considered.
• The CoAction board, has set aside specific funding to improve the address issues with both Bayview and Slip Lawn, in the immediate. Estimation of costing has been submitted by the Project Manager and is pending approval and sanctioning from the board.
• A quarterly walk around the designated centre is scheduled with the maintenance team, to ensure ongoing review and prioritization of repair and maintenance.

Regulation 17(1)(a)
1) In recent months, CoAction had been liaising with other organisations to explore the possibility of the use of alternative accommodation for the 4 residents of Bayview Seskin, so that major renovation work to Bay View could be undertaken as the only effective way to bring the property into total compliance with HIQA regulations.
However the proposed property was recently reviewed by an OT and has been deemed unsuitable to the assessed needs of the residents.
2) The Board of Trustees Buildings Advisory Group then undertook a review of the 19 & 20 Slip Grove properties within the designated center. Following this review these two houses have been deemed suitable for renovation and repurposing to house the residents of Seskin while Bayview Seskin is made fit for purpose on a permanent basis. In order to successfully achieve this 19 & 20 Slip Grove will be made into one house. Given the profile of the residents and clinical recommendations 3 ground floor bedrooms and one upstairs bedroom are required for the service users plus an upstairs staff bedroom.. To achieve this the following steps will be taken;
a. Final consultation with all residents at Seskin in relation to the proposed plan will take place in January 2024.
b. Architect/ Engineer will create the floor plans in line with HIQA's guidelines to be completed by the 9th of February 2024. The architect and engineer will consult with the clinical team, specifically the Occupational Therapist, to ensure the works are suitable to

the requirements of the residents.
c. At the same time consultations will be held with the current Respite users of the Slip Grove premises to discuss the alternative provision being offered.
d. An application to vary including floor plans will be submitted to HIQA in February2024 subject to successful consultation with residents. The condition that will be seeking variation will be based on Structural changes to the premises that are used as a designated center in line with the proposed works. If necessary the Statement of Purpose will be revised at the same time. It is anticipated that the variation will be approved within a month of application.
e. The plans for joining the two Slip Grove properties and refurbishing them internally do not require Planning Permission.
f. A contractor will be appointed during the period January & February. CoAction will ensure that the contractors awarded the job work in line with CoAction's External Contractor Policy, including but not limited to providing a risk management plan.
g. The contractors risk management plan, ongoing consultation with residents and clinical input will support creation of an internal CoAction risk management plan that will include the steps taken to ensure this change will not negatively impact on residents. This plan will be submitted to HIQA as is required with the application to vary.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Maintenance work has been done following the HIQA inspection to ensure all fire doors close properly and evacuation routes are safe and accessible to all residents.
• The sofa blocking access to safe evacuation has been removed.
• All resident personal evacuation plans are to be reviewed as a priority by the ADOS and PICS to ensure the correct staffing level is in place at all times to support safe evacuation of premises. Completion date: 19/01/2024
• The ADOS and PIC will ensure that a stimulated night time drill takes place to reflect the assessed needs of residents and a regular schedule of evacuation drills is put in place and any required supports around same established. Completion date: 31/01/2024

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:
• CoAction is currently undertaking a Person Centred Planning review to establish a baseline of plans in the designated centre. In order to ensure compliance with regulation,

work is underway to ensure that all residents, should they so wish, have a current person centred plan that reflects their goals and wishes. Completion date: 31/01/2024
• The Person in Charge and the Quality, Risk and Development Manager will meet with the Social Care Leader team on 18th January to discuss the Person Centred Plan, the importance of quality within the plans and the necessity to evidence the progression of identified goals and the regular timely review of plans.
• In line with regulatory requirements, any new resident admissions will be completed and recorded within 28 days of admission to the designated centre.

Along with the actions identified above, the following is also underway within the organisation;

• Management and Senior staff have received person centred planning leadership training.
• A HIQA/Reporting Oversight committee is to be established with oversight of all designated centre reporting systems. Completion date: 28/02/2024
• The Quality Risk and Development Manager is developing and supporting the delivery of audit tools for each of the local services that will underpin and enhance the current plans.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• All residents information will be kept in a secure and locked area that is compliant with GDPR.
• As noted above, ongoing HR recruitment strategies are being explored to increase the staffing levels within the designated centre. Furthermore, consolidation of services is being review to bolster existing services to allow for the increase in staffing to ensure that the residents goals are being realised.
• As noted above with regards to the Premises (17), plans are currently being devised to ensure compliances with regards to residents access to bathrooms for intimate and personal care. This plans are currently pending with the Board of Directors.
• A standing agenda item on house meeting will be implemented to note the activity wishes of the residents and how these can be facilitated.

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	19/01/2024
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	01/06/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	01/06/2024

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	01/06/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	01/06/2024
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	19/01/2024
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined	Not Compliant	Orange	19/01/2024

	management structure in the 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	19/01/2024
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	19/01/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management	Not Compliant	Orange	19/01/2024

	systems are in place.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	19/01/2024
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	13/12/2023
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	01/02/2024
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	01/02/2024
Regulation	The	Not Compliant		01/02/2024

05(7)(c)	recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.		Orange	
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	01/02/2024
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	01/02/2024