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:	Castletownbere Residential
Name of provider:	CoAction West Cork CLG
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	27 April 2023
Centre ID:	OSV-0002108
Fieldwork ID:	MON-0037410

About the designated centre

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

The service provided is a social care model that bases residents in their local community. The service is for adults with an intellectual disability who require either residential or respite services. Residents have access to day services locally and are supported to access employment should they wish to. The premises of this centre consist of two pairs of semi-detached houses which have been joined internally. One of these has an extension to the rear. These houses are located on the outskirts of a rural town. These are located within a hundred metres of each other. Bedrooms are located on both the ground and first floor, with each bedroom having an en-suite. Some bedrooms have track hoists. Each house has their own kitchen and sitting room, which are adequate to provide suitable common space for the residents. Each house has a garden to the rear. The staff team comprises of social care workers and care assistants with a team leader supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	0

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 27 April 2023	10:00hrs to 16:10hrs	Deirdre Duggan	Lead
Thursday 27 April 2023	10:00hrs to 16:10hrs	Lucia Power	Support

What residents told us and what inspectors observed

From what the inspector observed and from speaking to staff and management, residents who received respite supports in this centre were offered an appropriate service tailored to their individual needs and preferences. While overall, the service provided to residents that were currently using this centre for respite purposes was found to be good, this inspection found that some improvements were required. Ongoing recruitment and staffing issues meant that the respite service being provided had not fully resumed following the COVID-19 pandemic and one part of the centre remained closed at the time of this inspection. There was also evidence of lack of oversight by the management of this centre and non compliance was found in relation to notification of incidents, staffing, infection prevention and control and premises.

This centre had been closed for a long period since the COVID-19 pandemic. Only one unit of the centre was in use at the time of this inspection and that unit had reopened the month prior to the inspection and was providing respite services four nights a week.

The centre comprised two units in total. Each unit was made up of two interconnected large two storey houses located in a residential housing estate at the edge of a coastal town. As the centre had been closed for a period and did not offer full-time supports at the time of the inspection, the inspection was announced to the provider on the afternoon before it commenced to ensure that inspectors would have access to the centre on arrival. Inspectors reviewed documentation and spoke with some members of the providers' management team during the inspection. There were no residents present in the centre during the inspection but inspectors had an opportunity to meet with and speak to some of the respite residents that used this centre at their day service location located nearby, as was the residents' preference. Inspectors spoke at length with two residents in the kitchen of their day service location, and briefly with another on their return to the day service.

Inspectors met with three residents that were provided with respite services in this centre. All three residents had recently resumed attending the service and were pleased that this was happening. For example, one resident told inspectors "I'm glad my respite is back". However, there remained some uncertainty for residents and not all residents were receiving the same amount of respite in the centre that they had previously received.

Residents were complimentary of the service they received in the centre when they attended. They said they liked the houses that they stayed in and spoke positively about the staff that supported them. For example, one resident described staff and "kind, helpful, supportive" and that they were good at "empowering residents". Residents also told the inspectors about some of the activities they enjoyed taking part in while they were in the centre, such as baking, going out for meals and going for day trips. Residents told the inspectors that efforts were made to provide respite

at times when other residents that they enjoyed spending time were also in the centre. Two residents told the inspectors about the safeguarding arrangements in place in the centre and told the inspector that they felt safe in the centre. One resident discussed the changes in governance and management in the centre and how they had been informed of this and also spoke about the assisted decision making act.

Some respite residents had attended the centre weekly for up to four nights a week for a number of years prior to the closure of the centre and some of these residents told inspectors how the closure of the centre had impacted them and their families. One resident described how they were "hurt and sad" when the centre closed and spoke about how they considered the centre their home and how isolating it had been for them when the centre had been closed.

Residents met with during this inspection told inspectors that they did not feel that they were consulted with enough about the ongoing closure of the centre or the plans in place to reopen the centre. This will be further discussed in the quality and safety section of this report.

Inspectors completed a walk around of both units of the centre. Rooms were of a suitable size and layout for the residents that it was intended would use this centre and there was ample storage for residents belongings. Some ongoing maintenance works were required. For example, damage was noted to a bedroom door, water damage was noted to a windowsill in one bedroom and in a number of areas, the paintwork was seen to require some touching up.

In the unit that was unoccupied, it was evident that there had been little or no maintenance or cleaning of this unit in the period it had been unoccupied. Some rooms had odours present, there was evidence of dust and insect casings and as mentioned previously in this report, inspectors saw that food had been stored in the freezer since prior to the centre's closure in late 2021. Inspectors sought further assurances in relation to a fire door present in this unit also.

Overall, this inspection found that there was evidence of compliance with some of the regulations in this centre concerning the frontline care and support of residents and this meant that the residents currently receiving supports there were being afforded a person centred service that met their assessed needs. However, there was non-compliance with a number of regulations and the governance and management systems in place were not ensuring full oversight was being maintained of this centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Management systems in place in this centre did not provide full oversight of this centre and this meant that while the service provided was seen to be appropriate to the needs of the residents that were currently using the service, overall the service was not always safe and consistent for residents. Ongoing non compliance was noted in a number of areas. Non compliance was found in relation to governance and management, contracts of care, staffing, the notification of incidents and complaints.

This inspection was carried out to assess compliance with the regulations. The provider had submitted a number of compliance plan updates since the previous inspection that outlined the various steps they were taking to bring the centre into compliance with the regulation. This inspection found that although some of these actions had been completed, others had not yet occurred or had not been fully completed.

The Chief Inspector had been informed of a number of changes in relation to the management of this centre at provider level. The incoming Chief Executive Officer (CEO) met with the inspectors on the day of the inspection and outlined the changes that the provider was aiming to implement and reiterated the providers commitment to meet the regulations.

The person in charge was not present on the day of this inspection. This individual also occupied the role of service director and was often based in a location geographically distant from this centre. There was little evidence of this individuals' presence in the centre itself.

In the unit that had reopened, there was evidence of oversight by the local management team in the months prior to the inspection. There was a social care leader employed in the centre. The provider indicated that this individual would be stepping into the role of person in charge and in the weeks following the inspection, a notification was received in that respect. Residential staff meetings were documented and had recommenced since before the centre had reopened. Staff discussed various issues such as resident dynamics, finance, maintenance and plans for staff supervision during these meetings.

However, there was little evidence to indicate that oversight was maintained of the centre during the period it had been closed and oversight of the second closed unit remained poor. For example, none of the required notifications had been submitted in respect of the third or fourth quarter of 2022. Also, there was poor evidence of some parts of the premises being maintained. For example, the centre was not clean and there was a strong odour present, dates on food seen in the freezer showed that this had remained in the freezer since the centre had been closed in 2021. Also, Legionnaire's flushing was not being completed as will be discussed further in this report. A visitors log viewed in this unit did not contain any details of any visits or checks to this unit since the previous inspection in May 2022, apart from quarterly fire company visits.

While an annual review and a report on the provider six monthly unannounced

audits had been completed, these do not reflect the resident status at the time of the reports and did not identify the lapses in oversight noted on this inspection. The provider did not demonstrate that there was oversight in relation to the actions identified in the previous HIQA inspection May 2022. The provider had committed in their action plan to come into compliance, however on the day of inspection there was limited evidence in relation to some of these actions. For example the provider had noted in their compliance plan response that a residential forum would be set up for residents, on the day of inspection this forum was still not established for residents.

A complaints log was viewed and some complaints were seen to have been recorded in the year to date. Some actions had been identified on foot of complaints and there was evidence that complaints were responded to. However, it was seen that the outcome of the complaint and the satisfaction of the complainant had not been recorded for a number of the complaints viewed.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

When the centre was operational, the number and skill mix of staff was appropriate to the assessed needs of the residents in the service. However, the centre had closed unplanned on one occasion at short notice due to the unavailability of a full staff team to support residents. Staff rotas provided to the inspectors did not contain full details, such as details relating to the cover provided at night.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Incomplete training records were available on the day of the inspection. The person in charge provided further information to inspectors following the inspection. Overall, staff in the centre had access to appropriate training including safeguarding training and fire safety training. Some refresher training was overdue and this had been scheduled for completion, with most of this scheduled to occur in the month following the inspection.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre and was made available to the inspector. This contained the required information specified in the regulations. An inaccuracy in relation to the recording of some of the information about residents presence in the centre is covered under Regulation 21: Records.

Judgment: Compliant

Regulation 21: Records

Records were not always accurately maintained. For example, four residents were recorded to have been present overnight in the centre on one occasion when the centre had been closed due to staff shortages. Also, a full and complete staff roster was not available in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

Despite ongoing recruitment efforts, the provider did not ensure the service was resourced to effectively staff the centre in line with the statement of purpose and this continued to impact on residents who availed of long term respite services in the centre. There was poor evidence of management and provider oversight in the centre. There was little evidence to show that the person in charge was involved in the day-to-day running and oversight of the centre and the providers' annual review and six-monthly audit had not identified a number of ongoing issues and risks in the centre. For example, the risk of Legionairres had been identified on the risk register but there were no control measures in place to ensure that this risk was being mitigated against during periods when the centre, or parts of the centre were closed for long periods.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Some non compliance remained in relation to the contracts of care in place. The contracts in place did not define the type of services provided and the most recent compliance plan received in respect of this indicated that new contracts of care

would be in place by December 2022. However, new contracts had not been reviewed by the board of management. It is acknowledged that this was due to ongoing changes in the board of management and there were plans in place for this to be completed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The designated centre's statement of purpose was viewed and was available in the centre. This document contained the required information as set out by the regulations and described the facilities and services to be provided in the centre. Some clarifications were made to the statement of purpose and an updated version was submitted to the office of the chief inspector in the days following the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents had been reported as required. None of the required notifications had been submitted in respect of the third or fourth quarter of 2022.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints procedure in place and some complaints were viewed in the complaints log of the centre. However, not all complaints were not recorded fully. For example, not all complaints recorded included the outcome of the complaint or the satisfaction of the complainant.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures were available as set out in Schedule 5 and these had been

reviewed and updated as appropriate.

Judgment: Compliant

Quality and safety

Residents confirmed that they received a good standard of care and support when they availed of respite supports in this centre and overall the evidence showed that safe and good quality supports were provided to the residents that were availing of respite services at the time of this inspection. However, improvements were required in relation to the documentation in place around personal plans, maintenance and infection control procedures, and how residents were communicated with about some aspects of the service. Non compliance was found in relation to residents' rights, infection prevention and control, fire precautions and premises.

The statement of purpose outlined that this centre could provide supports for 5 full time residents and 8 part time respite residents. It further outlined that two of the full time places were occupied and that these residents were being supported by the provider in other designated centres until their full-time service could be resumed in this centre. The inspectors were informed that one of these residents had expressed a wish to remain in the centre they were currently living in and it was evident from records viewed in the centre that there was ongoing discussion occurring in relation to this.

As referenced previously in this report, some residents were unhappy with how they had been consulted with in relation to the ongoing closure of the centre. Residents told inspectors that they were told on a number of occasions that the centre "would be open soon" but the dates the centre was due to open were pushed out repeatedly. The annual review and the most recent compliance plan update received made reference to link meetings that were occurring between the provider and family representatives to keep them informed about the reopening and plans for the centre. Management spoken with on the day of the inspection also discussed these but there were no records in place to evidence that these had or were taking place as described. There was also little evidence to show that residents themselves were regularly communicated with in a formal manner about ongoing issues in relation to the reopening of the service. The contact sheets viewed included only records since February 2023 and did include any information about how residents and their representatives were included. Family/friend contact records viewed in the centre showed that there was good consultation with residents' representatives while residents were present in the centre, if required.

The inspectors viewed both units of the centre during the inspection. The unit that was occupied was seen to be reasonably clean throughout. Some paintwork had been completed but it was observed that painting was still required in some areas.

Emergency procedures had been updated to reflect some changing information. Some equipment was seen to have been recently serviced. However, there were no up-to-date records in place for some other equipment, such as some of the overhead hoists in place. The inspectors were told that these were not in use as the residents that used those rooms did not require such equipment but that all equipment had recently been serviced. However, there was no information available to staff to indicate that these were not in use and on the day of the inspection it was unclear if these had been recently serviced or not, or were fit-for-use. The inspectors requested further information in relation to this. The person in charge later informed the inspectors that these hoists were indeed no longer in use and that there was now signage displayed to indicate this to staff.

Since the centre had reopened, cleaning checks indicated that regular cleaning was being completed in the open unit on the days that it was occupied. There were no records in place to indicate that cleaning was carried out on the other unit, and a visual inspection indicated that this was not occurring. Inspectors viewed a risk assessment relating to the risk of Legionella, a bacterium that can be a health concern in buildings. This had been signed as reviewed in January 2023 but this risk assessment continued to refer to one shower only and did not take into account the Legionella risks associated with the units in the centre being closed for a prolonged period of time. There was no evidence that flushing of water pipes was occurring or had occurred.

Overall, the inspectors saw that the lived experiences of residents when in this centre was very good. Residents had choices in relation to their daily activities, foods and who they shared their home with during periods of respite. On one occasion the centre had closed at very short notice and arrangements had to be made for residents to return home, despite respite being planned. Residents expressed their disappointment in relation to this and spoke about the inconvenience associated with this, having arrived to day services with their belongings ready to attend their respite service. The previous inspection found a number of issues in relation to residents' rights (Regulation 9), with many of these issues related to the ongoing closure of the centre and how residents were communicated with about this. The most recent compliance plan received in respect of this centre indicated that this centre would come into compliance with this regulation. This included details about how a residential forum would be established and how communication with residents was ongoing. This also made reference to the link meetings which were referred to earlier in this report. This inspection found that these link meetings were not formal meetings that were recorded and limited evidence of communication with residents and/or their representatives about the ongoing closure of the centre and the plans to reopen the centre. A residential forum had not yet been established at the time of this inspection.

Residents' personal plans were reviewed by inspectors during the inspection. Support plans in place were seen to be detailed and provide good guidance. Plans viewed were seen to focus on maximising residents' independence where possible. For example, one resident with a visual impairment had a detailed support plan in place around enhancing their independence when making tea, with additional supports in place to maximise independence while reducing the associated risks

attached as much as possible. While residents were seen to have participated in person centred planning meetings, these had taken place in conjunction with day services and were not specific to the residential service, although references where included to respite services. Some information in these plans was seen to have been updated in the period before or since residents had returned to respite services but some information was seen to reference the other unit previously used by these residents, which remained closed at the time of this inspection.

Healthcare plans were in place for residents and these provided good guidance for staff. Up-to-date hospital passports were viewed in a sample of personal files. This would provide for continuity of care and should provide guidance to other care providers should a resident need to transfer to hospital.

The fire precautions in place were reviewed. There was evidence that equipment such as fire extinguishers had been serviced at regular intervals as required. Residents had taken part in appropriate evacuation drills since the centre had reopened and daily fire safety checks had been completed on the days that the centre was open. While it was seen that some personal emergency evacuation plans (PEEPs) had been reviewed since the residents' return, some contained information relating to the unit that was closed. Also, in the unit that was closed, a self-closing mechanism on one door was seen not to be operating correctly and another door was not closing fully.

Regulation 17: Premises

Overall, the premises were suitably laid out to meet the assessed needs of residents. Some painting works had been completed. However, some maintenance works were required in both units and there was evidence that the unit that was closed at the time of the inspection was not being maintained regularly. For example, there was odours present throughout the house, damaged services were observed and the centre had not been cleaned in some time.

Judgment: Not compliant

Regulation 27: Protection against infection

There was no evidence of ongoing cleaning and maintenance in one part of the centre, which had been closed for a long period, and there was no oversight of infection prevention and control concerns that this might present. For example, there was no evidence of Legionnaire's flushing being completed while the centre, or parts of it, were unoccupied and the risk assessment in place in relation to this did not accurately reflect the current situation in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

Some fire doors required review to ensure that they would be effective in the event of an outbreak of fire in the centre. Some personal evacuation plans in place did not contain up-to-date information and did not reflect the current arrangements in place. For example, some of these had not been updated to reflect the current location that residents were receiving their respite service in. Also, it was not clear that residents have visual impairments, for example, and evacuation plans in place did not outline plans for the evacuation of full units such as staff supports required and lines of responsibility.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A sample of personal plans were reviewed. Support plans were in place that provided good guidance for staff. Some of these were seen to relate to day services and person centred plan meetings were seen to have taken place with day services. However, some plans viewed had not been fully updated to reflect a return to respite service and did not reflect the current location that residents were receiving respite.

Judgment: Substantially compliant

Regulation 6: Health care

There was evidence that appropriate health care was provided to residents in line with the type of service that was offered in this centre. A sample of health care plans were reviewed. These were seen to contain appropriate information to guide staff and had been updated as required.

Judgment: Compliant

Regulation 8: Protection

Residents told the inspectors they felt safe in this centre and were familiar with the

safeguarding procedures in the centre. Staff had received appropriate training in safeguarding.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had choices in relation to their daily activities, foods etc. Ongoing non compliance was found. Residents were not always adequately consulted with in relation to the operation of the centre and there was little evidence to suggest improvements had been made in relation to residents access to advocacy services. An unplanned closure of the centre at short notice had recently impacted some residents and the ongoing closure of one unit of the centre continued to impact residents' privacy and dignity in relation to their personal and living space.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not 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	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Castletownbere Residential OSV-0002108

Inspection ID: MON-0037410

Date of inspection: 27/04/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A new staff rota was developed in the Designated Centre in order to ensure that all details required are included. The rota now identifies staff full names, grade and identifies the staff member providing cover at night. This rota is now in use in the Designated Centre. Completed. The provider ensures that every effort is made before making the decision to close the centre at short notice. Should a closure be required, the provider will inform residents immediately. The provider is continually attempting to recruit for the centre. In addition to the recruitment, the provider is engaging with agencies in order to have staffing available for short notice staffing issues to eliminate any short notice cancellations. The provider has been successful in recruiting a HR Manager and they took up the post at the end of June 2023.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The training matrix has been reviewed and all in person training due for staff has either been completed or is scheduled. A new relief staff member has joined the team since the inspection and is currently completing all required trainings.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A new staff rota was developed in the Designated Centre in order to ensure that all details required are included. The rota now identifies staff full names, grade and identifies the staff member providing cover at night. This rota is now in use in the Designated Centre. The Person in Charge will ensure that all records will be accurately recorded within the Designated Centre.	
Regulation 23: Governance and	Not Compliant

management	
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Social Care Leader has been identified to be registered as the Person in Charge of the Designated Centre. This staff member works within the Designated Centre and will provide presence and oversight with regards the running of the centre. The centre is currently operating four nights per week. The provider ensures that every effort is made before making the decision to close the centre at short notice. Should a closure be required, the provider will inform residents immediately. The provider is continually attempting to recruit for the centre. In addition to the recruitment, the provider is engaging with agencies in order to have staffing available for short notice staffing issues to eliminate any short notice cancellations. The provider has been successful in recruiting a HR Manager and they took up the post at the end of June 2023. In order to ensure that the 6 monthly unannounced provider inspections identify issues within the Designated Centre, a review of the current auditing system has taken place. The review ensures that concerns pertaining to the safety and quality of care and support within the Designated Centre are identified. Any identified issues will then form part of the Regulation 23 6 monthly unannounced visit report so as a plan can be put in place to address any concerns. This auditing document will be reviewed and updated on an ongoing basis and as required. The incoming Person in Charge will ensure that issues pertaining to the Designated Centre are identified in the annual review.	
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: Contracts of Care have been reviewed by the Director of Services and Assistant Director of Services to ensure that all appropriate information is present. These have now been approved by the Board of Trustees. Contracts of Care for each resident have been sent to the incoming Person in Charge in order for residents and if appropriate, their representatives to be consulted.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The incoming Person in Charge will ensure that all notifications will be completed as per regulation.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The incoming Person in Charge will ensure that the staff team document all stages of the complaints process, including the outcome and satisfaction of the complainant.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

The incoming Person in Charge will do a walk-through of the Designated Centre with the Building and Transport Manager in order to identify all maintenance works that are required. Following this, a schedule of works will be compiled and will identify if the provider's maintenance person can complete the work or if an external contractor will be required.
The incoming Person in Charge will ensure that the required cleaning schedules/infection prevention checks/health and safety for the house that is currently not in use are in place and maintained appropriately.
A deep clean for the house that is not in use has been scheduled.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The incoming Person in Charge will do a walk-through of the Designated Centre with the Building and Transport Manager in order to identify all maintenance works that are required. Following this, a schedule of works will be compiled and will identify if the providers maintenance person can complete the work or if an external contractor will be required. The incoming Person in Charge will ensure that the required cleaning schedules/infection prevention checks/health and safety for the house that is currently not in use are in place and maintained appropriately.
A template for the recording of flushing of all water systems in the Designated Centre has been devised and is in operation.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The fire doors in the Designated Centre have been reviewed and all are in working order.
Personal evacuation plans have been updated and now contain all accurate and up-to-date information

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The incoming Person in Charge will ensure that the residential team will consult with residents to offer them an opportunity to review their personal plans. This will be done with the residents circle of support in order to reflect to re-opening of the respite service.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The incoming Person in Charge, local hub manager and Director of Services will host quarterly formal residential forums with the residents in Castletownbere Residential.
All residents in Castletownbere have access to the national Advocacy Service.
An information sharing session will take place for the residents of Castletownbere Residential regarding access to advocacy services, how to make a complaint and the detail of the confidential recipient.

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.	Substantially Compliant	Yellow	30/09/2023
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	03/05/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	30/08/2023

	as part of a continuous professional development programme.			
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.	Not Compliant	Orange	30/09/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/09/2023
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/07/2023
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	30/07/2023
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/09/2023

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Substantially Compliant	Yellow	11/08/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/09/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	19/07/2023
Regulation	The registered	Substantially	Yellow	19/07/2023

28(3)(d)	provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Compliant		
Regulation 31(4)	Where no incidents which require to be notified under (1), (2) or (3) have taken place, the registered provider shall notify the chief inspector of this fact on a six monthly basis.	Not Compliant	Orange	31/07/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/07/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account	Substantially Compliant	Yellow	30/11/2023

	changes in circumstances and new developments.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	31/08/2023
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/08/2023
Regulation 09(2)(d)	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 access to advocacy services and information about his or her rights.	Not Compliant	Orange	31/08/2023
Regulation 09(2)(e)	The registered provider shall ensure that each	Not Compliant	Orange	31/08/2023

	resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.			
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	31/08/2023