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:	North County Cork 4
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	07 March 2023
Centre ID:	OSV-0003294
Fieldwork ID:	MON-0030201

About the designated centre

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

North County Cork 4 is a large one-storey building house located in a town. The centre can provide residential services for a maximum of 10 residents of both genders, over the age of 18. Residents with intellectual disability and/or autism and a mental health diagnosis are to be supported in the centre. Support to residents is provided by the person in charge, staff nurses and care assistants. Each resident has their own bedroom and other facilities in the centre include bathrooms, a living room, a dining room, a kitchen, a utility room and a staff office.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Tuesday 7 March 2023	09:50hrs to 18:30hrs	Kerrie O'Halloran	Lead

What residents told us and what inspectors observed

This was an announced inspection, completed to inform the decision making with regard to the renewal of the centre's registration. The inspector was greeted by the person in charge on the morning of the inspection. There were ten residents living in the centre and the inspector had the opportunity to meet with all ten of the residents during the course of the inspection day. One resident choice was respected by the inspector and this resident choose to wave hello and not speak with the inspector. Some residents had left the centre that morning to attend their day service which was located adjacent to the designated centre and while other residents were retired or semi-retired and chose to remain in the designated centre during the day. Staff were observed to support the residents who remained in the centre throughout the day in a caring and respectful manner. The inspector observed the staff supporting residents in a variety of activities throughout the inspection day such as, art and crafts, music, puzzles, relaxation, walks and drives in the local community. Some residents were observed relaxing in their living room watching television in the afternoon and others were observed chatting with staff. In the afternoon the inspector met residents who had returned from their day service.

All residents the inspector spoke with told the inspector they were happy, enjoyed living in the centre and identified other residents whom they were friends with. The residents indicated they would speak to the staff or person in charge if they had a complaint or if they were unhappy. Residents were supported with active daily lives. For example on the day of the inspection, some residents attended yoga in the afternoon and another resident spoke to the inspector about their employment in a local shop which was important to them.

The designated centre was a large bungalow which consisted of ten individual resident bedrooms, a kitchen, a dining room, a sitting room, a lounge/visitors room and a laundry room. On the day of the inspection preparation for paintwork to be completed in the coming days had commenced in the designated centre. The person in charge informed the inspector that the residents' had chosen the colours of their own bedrooms and had all been consulted in paint colours for the communal areas. All residents had personalised their rooms to suit their preferences, pictures and personal items were noted around residents' rooms. Overall, the premises was seen to be well presented, clean, homely and well furnished. Some maintenance works was required in one residents en-suite and communal bathrooms. These were seen by the inspector to have damage to flooring around shower, rust present on hand rails, shower area discoloured around tiles and seals.

Residents presented with various levels of support needs and there were busy periods during the day such as mornings, evenings and meal times when some residents would need full support with personal care, toileting and transfers. The staff team comprised of nursing staff and care support workers. Positive and respectful interactions were noted between staff and residents during the inspection day. The inspector spoke with five staff and they appeared knowledgeable regarding

the residents needs and were familiar with the general day to day running of the designated centre.

Recent three day notifications submitted to the Chief Inspector identified ongoing safeguarding concerns in relation to residents of the centre expressing to staff and the person in charge that they were unhappy, upset and their daily lives on occasions were being impacted by a peer vocalising loudly. From speaking to the person in charge the compatibility of the residents living in the designated centre was discussed. The person in charge informed the inspector that a referral for a compatibility/ impact assessment was in place. The person in charge had recently met with all ten residents in the designated centre regarding this, seven residents expressed their unhappiness with the ongoing disturbances. One resident complained of sleep disturbances. One resident had submitted a complaint in recent months as they communicated that they were upset due to a peer shouting in their presents. This was one incident which was not submitted to the office of the chief inspector within the required time frame. This will be discussed further in the report and under regulation 31.

The next two sections of the report present the finding of the 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

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

There were clear lines of authority and accountability within the centre. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge had remit over two designated centres and spoke with the inspector about the management systems they had in place to ensure that they were able to maintain full oversight of both centres.

The person in charge had systems in place to monitor the quality and safety of the service delivered to residents, such as intimate care audits, statement of purpose audit, finances audit, cleaning audit and weekly/monthly oversight procedures in place to ensure relevant issues were escalated appropriately. The registered provider had measures in place to maintain oversight of the centre. The registered provider had ensured that an annual review had been completed in 2022. The reflections of family representatives were also included in this review, which were positive. In addition unannounced audits were completed six monthly in line with the regulations. The last of which was completed in March 2023. The person in charge had completed some of the actions which were identified by the provider and had identified plans in place to met actions within an agreed time line.

On the day of inspection, there was an experienced and consistent staff team in place in this centre and there were sufficient numbers of staff on duty to support residents. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner. From a review of the roster, it was evident that there was an established staff team in place and the use of regular relief staff which ensured continuity of care and support to residents.

There was a programme of training and refresher training in place for all staff. The inspector reviewed the centre's staff training records and found that it was evident that the staff team in the centre had not received some of the providers training in management of actual or potential aggression and manual handling. Staff in the centre received supervision from the person in charge as per the providers policy. These measures were in place to ensure all staff had the opportunity to raise concerns or for issues to be addressed.

A complaints policy was present within the centre giving clear guidance to staff in relation to the complaints procedure. Details of the complaints officer was accessible in the centre. A complaints log was maintained by the person in charge. The inspector spoke to one resident who indicated they would talk to a staff member if they had a complaint. The registered provider also had a directory of residents that was properly maintained with all required information.

As mentioned previously in the report, prior to the inspection the person in charge informed the inspector about two incidents that had occurred in the weeks and months previous to the inspection, these had not been notified to the Authority in a timely manner. Following this the person in charge submitted these notifications retrospectively.

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.

Registration Regulation 5: Application for registration or renewal of registration

As required by the regulations the provider had submitted an appropriate application

to renew the registration of the centre along with the required prescribed documents.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge demonstrated the relevant experience in management and had a good understanding of the regulations. The person in charge ensured there was effective governance and operational management in the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. From a review of the roster, there was a staff team in place as per the statement of purpose which ensured continuity of care. The staff team comprised of nursing staff and care support workers. The provider had ensured staffing numbers were in place to meet the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

A number of staff were still outstanding on mandatory and refresher training. Nineteen staff were due to complete either initial or refresher training in management of actual or potential aggression which was a requirement for this designated centre. Two staff members were overdue refresher manual handling training, which the person in charge had identified and this was scheduled for these staff members.

The person in charge had a schedule in place to complete one to one formal supervision/appraisals sessions with the staff as per the providers own policy.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was present in the centre and was available to the inspector for review. It was found to contain all information as required by the Regulation and Schedule 3.

Judgment: Compliant

Regulation 22: Insurance

The provider had a contract of insurance in place that ensured the centre and the residents were protected.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure within the designated centre. The management systems in place ensured that the service being provided was safe, appropriate to the residents' needs, consistent and effectively monitored. The person in charge carried out various audits in the centre on key areas relating to the quality and safety of the care provided to residents. Where areas for improvement were identified within these audits, plans were put in place to address these. Additionally, the provider had ensured that the annual review had been completed for the previous year. The overall compliance levels for the centre had improved since the previous HIQA inspection in July 2022.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose and function for the designated centre. This is an important governance document that details the care and support in place and the services to be provided to the residents in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The chief inspector had been notified of a number of incidents that had occurred in this centre as appropriate. Prior to the inspection the person in charge informed the inspector about two incidents that had occurred in the weeks and months previous to the inspection. These had been not submitted to the office of the chief inspector within the required time frame. These were submitted by the person in charge in the coming days after contacting the inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

Residents were protected by the complaints policies, practices and procedures in the centre. There was a log maintained of complaints and from the sample of complaints reviewed in the centre they had been recorded and followed up on in line with the organisations' policy. The person in charge had reviewed complaints prior to this inspection and a complaint received in February 2023 contained information of a safeguarding nature. These notifications were submitted retrospectively to HIQA. This was reviewed under regulation 31.

An easy-to-read complaints process was on display and this contained pictures of the relevant staff. The complaints process was regularly reviewed at resident meetings and residents indicated via their responses in questionnaires and in speaking to the inspector on the day of the inspection that they were aware of the process.

Judgment: Compliant

Quality and safety

The governance and management arrangements ensured that a safe and quality service was delivered to residents. The findings of this inspection indicated that the provider had the capacity to operate the service in compliance with the regulations and in a manner which ensured the delivery of care was person-centred. Some issues were identified in relation to premises, individual assessments and personal plans, protection, residents' rights, health care, protection and medicines.

The specific communication needs of residents had been identified and were supported through practices in the centre. Residents were supported to communicate using preferred methods, such as, LAMH. Staff were observed to interact with residents' consistent with their communication needs. All residents had access to internet and television.

The centre was equipped with fire safety systems including a fire alarm, emergency

lighting, fire extinguishers and fire doors. Fire safety systems were being serviced at regular intervals by an external contractor to ensure they were in proper working order. Fire drills were being carried out regularly, including to reflect times when staffing levels would be at their lowest. The fire evacuation procedures were on display in the centre and records indicated that staff had undergone relevant fire safety training. Each resident had a personal emergency evacuation plan (PEEP) in place which identified a personal evacuation plan for day and night, and there was an overall centre evacuation plan in place also to guide staff.

A recent quarterly notification submitted to the Chief Inspector, indicated that all residents in this centre had restricted access to their own money. The inspector queried this during this inspection and it was indicated that the money of three residents was managed by their families and that money for these residents had to be requested from their family members. It was emphasised by the person in charge that any money requests for these three residents were met. For the other seven residents it was indicated that they had bank accounts in their own name but that these accounts were managed centrally by the provider. Under this arrangement in order for residents to gain access to their money, a requisition form had to be completed by the person in charge which was then submitted to the provider for review. Once this requisition form was approved it would then be necessary for residents and/or staff to drive from this centre to the provider's central offices to collect the money. The inspector was informed the process would take between two to four days for approval and collection. It was noted that these practices were long-established arrangements, however it did not provide assurance that residents had sufficient control over and ease of access to their own money.

It was seen that arrangements were in place to ensure that residents were able to retain control over their personal possessions in this designated centre. These included having suitable facilities available for residents to store their personal possessions. The person in charge had ensured each resident had an inventory list completed and was regularly reviewed. These lists were found to be detailed in providing descriptions of the possessions that residents owned.

The inspector reviewed a sample of residents' personal plans. Each resident had an up-to-date assessment of their personal, social and health needs. Residents' support plans reviewed were found to be up to date and suitably guiding the staff team in supporting the residents with their needs. Residents had goals in place, some which were individualised and meaningful to the resident, for example a resident who had expressed a desire to move out of the designated centre had goals to progress their daily living skills and explore options to a new living arrangement. Other residents goals were seen to be repetitive to 2022 goals with no evidence of the development of goals in line with a residents personal interest. For example, one resident had a goal to maintain family contact and on review of the documentation the resident had ongoing family contact throughout their lives.

There were systems in place for the safeguarding of residents. The inspector reviewed incidents occurring in the centre for the previous 12 months, this demonstrated that incidents were reviewed and appropriately responded to. The person in charge had put in place systems for oversight of incidents to ensure

residents were kept safe. The residents were observed to appear comfortable and content in their home.

The inspector found that the service provider had systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for COVID-19 in relation to staffing and the self-isolation of the residents. The designated centre was visibly clean on the day of the inspection and had comprehensive cleaning schedules in place.

Regulation 10: Communication

Residents were supported to communicate in accordance with their assessed needs. Individual communications needs had been identified and residents were supported to communicate using preferred methods, such as LAMH. The inspector viewed a communication book for a resident which identified alternate signs this resident uses to communicate with staff, other residents and visitors. All residents had access to internet and television.

Judgment: Compliant

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner. Some areas were in need of renovation but there was a plan in place for the necessary work. For example, on the inspection day the designated centre was preparing for painting works to commence. The staff team had supported residents to display their personal items and in ensuring that their personal possessions and pictures were available to them throughout the centre. All residents had their own bedrooms which were decorated to reflect their individual tastes.

However some additional works were required to a residents en-suite and communal bathrooms. These were seen to have damage to flooring around shower, rust present on hand rails, shower area visibly discoloured around tiles and seals.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider prepared a residents guide which contained the required information as set out by the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured the safety of residents was promoted through risk assessment and learning from adverse events. It was evident that incidents were reviewed by the person in charge and learning from such incidents informed practice and was discussed at team meetings. There were systems in place for the assessment, management and ongoing review of risks in the designated centre. For example, risks were managed and reviewed through a centre specific risk register and individual risk assessments. The individual risk assessments were up to date and reflective of the controls in place to mitigate the risks.

Judgment: Compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for COVID-19 in relation to staffing and the self-isolation of residents. There was infection control guidance is in place in the centre. The inspectors observed that the centre was visibly clean on the day of the inspection. Cleaning schedules were in place for high touch areas, regular cleaning of rooms and some personal equipment. Good practices were in place for infection prevention and control including laundry management and a color-coded mop system.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. All staff have received suitable training in fire prevention and emergency procedures. There were adequate means of escape, including emergency lighting. For example, escape routes were clear from obstruction and sufficiently wide to enable evacuation, taking account of residents' needs. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. There was evidence of regular fire evacuation drills taking place in the centre, including minimal staffing drills.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had systems in place for the safe administration, prescribing and storage of medicines. Medicines were stored securely in a locked cabinet. Stock records were maintained of all medicines received into the centre. Appropriate facilities were provided for medicines which needed to be refrigerated. Where a resident required support from staff or wished to take responsibility of their own medicines, they were risk assessed and an assessment took place to do so. However on review of a sample of records these were not updated annually and one resident had not been assessed to do so since 2021.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed a sample of residents' personal files. Each resident had an assessment which identified the resident's health, social and personal needs. The assessment informed the resident's personal plans which guided the staff team in supporting residents with identified needs, supports and goals. Staff were observed to implement the plans on the day of inspection and were seen to respond in a person-centred way to residents. For example, a staff member was observed giving a resident a choice of activity in the afternoon in the designated centre.

Some residents were seen to have in place goals that were meaningful to them and reflected their individual wishes and capacities. However, some residents individualised plans did not fully outline the supports required to maximise the resident's personal development in accordance with his or her wishes. For example, some residents had goals in place that were seen to be repetitive with no reflection evident to ensure continuous development and some goals in place were seen not to be individualised to the interests of the residents.

Judgment: Substantially compliant

Regulation 6: Health care

Each residents' health care supports had been appropriately identified and assessed. The inspector reviewed a sample of health care plans and found that in the most part they appropriately guided the staff team in supporting residents with their health care needs. However, some review of these health care support plans were

needed to accurately reflect the supports in place. For example, it was identified for one resident bloods to be completed every six months to monitor health condition, these were not being completed every six months but annually. The person in charge had ensured that residents were facilitated to access appropriate health and social care professionals as required.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and positive behaviour support guidelines were in place as required.

There were systems in place to identify, manage and review the use of restrictive practices. There were a number of restrictive practices in use in the designated centre which had been appropriately identified as restrictive practices and reviewed on an ongoing basis.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding and protection. The person in charge and the person participating in management assured the inspector of the reviewed processes in place for ongoing monitoring of safeguarding incidents to ensure oversight and timely reporting procedures to the Chief Inspector. All staff had completed training in relation to safeguarding and protection and were found to be knowledgeable in relation to their responsibilities. Residents had intimate care plans in place which detailed their support needs and preferences, however from the sample reviewed it was seen that a residents intimate care plan was overdue for review as per the providers policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider is supporting a resident with their expressed wishes to move out of the designated centre. Since the previous inspection the inspector reviewed records of multi-disciplinary meetings to support the resident with their wishes and the registered provider had plans and actions in place to achieve this. The resident

currently remained on the waiting list for an independent advocate and the person in charge was aware of this.

The residents' capacity to manage their own financial affairs had been assessed in the last twelve months. However, in order for residents' to access their own finances, a requisition form had to be completed and approved and some travel also had to be undertaken for the residents whose finances were managed by the provider. Three residents' finances were being managed by their families, this was not clearly identified in the resident's financial assessments and there was no evidence of consent from residents that this was their expressed wishes.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for North County Cork 4 OSV-0003294

Inspection ID: MON-0030201

Date of inspection: 07/03/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Refresher training for manual handling has been scheduled for the two staff out of date. To be completed by 19.04.2023 • Due to a review of the decision-making process in relation to Safety Intervention training, staff were out of date of this training. The organisation has finalised the process and all staff will be booked on the training as it becomes available. To be completed by 31.07.2023	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • As per regulations, the PIC is aware that notifications are required within a specific time frame and always endeavour to achieve this. Two retrospective notifications were dealt with as complaints at the time they were made, however on further review of complaints the PIC felt that these were indeed safeguarding issues. The third retrospective notification was identified by the Safeguarding Protection Team on feedback. Completed on 25.2.2023 • From the review process, lessons learned have been taken and these will be applied going forward in thoroughly examining all complaints/safeguarding at the time they are reported. The PIC will continue to liaise with the DO and PPIM in relation to any incidents that may occur in the future to ensure that potential safeguarding is identified and dealt with in a timely manner. To be scheduled in monthly meetings with PPIM. Next meeting	

25.04.2023.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • 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 by ensuring the facilities manager reviews premises annual or more sooner if required. To be completed by 30.06.2023 • The Person in Charge has developed a safety / maintenance schedule to be completed monthly following a walk about of the centre to identify works required in the designated centre and these are submitted through the PEMAC online system. The PPIM follows up with the facilities department at monthly resource meeting. Next scheduled meeting 17.04.2023. • PEMAC for damage to flooring around shower, rust present on hand rails and discolouration around tiles and seals submitted on 2.03.2023. To be completed by 31.08.2023. • Refurbishment of residents ensuite has been approved. To be completed by 30.09.2023	

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • All resident's capacity to self-medicate risk assessments to be reviewed and updated. To be completed 20.04.2023. • A schedule for annual review of assessments will be developed to be completed annually, this will be completed by 20.04.2023. • Current medication audit will be updated to include review of the self-medicate risk assessments, this will be completed by 20.04.2023.	

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:
• PIC has developed a process and schedule for review of goal progression and communicated to all staff. Completed on 17.04.23
• PIC has developed her own schedule for auditing and monitoring care plans to ensure effective oversight. Completed on 14.04.23
• Training for PCP goal setting will be completed by 31.07.2023
• All PCP goals will be reviewed by the keyworker in conjunction with the resident, to ensure personal goals are considered with the residents choice and supports required to maximise the resident's personal development in accordance with his or her wishes. To be completed by 31.07.2023

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• PIC has developed a process and schedule for review of personal plans including healthcare and communicated to all staff. Residents blood monitoring has been scheduled in the residential diary for all residents. Completed on 17.04.23
• One resident whose bloods were omitted to be completed six monthly had bloods completed on 22.03.2023
• PIC has developed her own schedule for auditing and monitoring personal plans to ensure effective oversight. All personal plans to be reviewed in conjunction with the resident. To be completed by 30.06.2023

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• PIC has developed a process and schedule for review of care plans including healthcare and this process has been communicated to all staff. Completed by 17.04.23
• All intimate care plans have been reviewed and updated. Completed by 31.03.2023

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• To ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights, the provider is currently creating a process for residents who have their personal money in a nominee account to be issued with a card in their own name for easier access to personal finances. To be completed by 15.01.2024.
• Residents who are supported by family members to manage their finances will be supported through easy read documentation to give formal consent for this process if they so wish. This consent will be documented in their personal plan . To be completed by 31.05.2023

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/07/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2023
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take	Substantially Compliant	Yellow	20/04/2023

	responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	25/02/2023
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.	Substantially Compliant	Yellow	31/07/2023
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal	Substantially Compliant	Yellow	30/06/2023

	plan.			
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	31/03/2023
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	15/01/2024