Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 16
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	18 May 2022
Centre ID:	OSV-0003292
Fieldwork ID:	MON-0032270

About the designated centre

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

Cork City North 16 is located in a residential setting on the outskirts of the city and consists of two adjoining bungalows which provide a home for up to four adults. The centre is comprised of four single bedrooms, two bathrooms, kitchen-dining room, sitting room, multi-sensory room, utility room, staff toilet and office. There is a secure garden area to the rear of the property and small grassed area at the front with parking facilities. The centre provides full residential care for residents. Weekend short breaks are also provided to a number of adults when a resident goes home for the weekend. The centre caters for adults with an intellectual disability who may also have additional multiple and complex needs. The centre aims to provide a high quality service in partnership with families and carers, with each resident being valued for their own uniqueness.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 18 May 2022	08:30hrs to 17:05hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

Although residents were safe and enjoying a good quality of life in the centre, improvement was required in the governance and management systems in place to improve oversight to ensure that residents were receiving a high quality service.

This was an unannounced inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

The centre was a single-storey house, in a residential area on the outskirts of Cork City. Originally it was two semi-detached houses, however was now one detached building. The centre was registered to accommodate four adults. Prior to the COVID-19 pandemic, a short breaks / respite service was provided in one bedroom at times when a resident was not there at the weekend. The person in charge informed the inspector that this service was no longer provided in the centre. These residents now received a respite service in another designated centre operated by the provider. At the time of this inspection, four residents lived in the centre on a full-time basis.

Each resident had their own bedroom. Photographs of relatives and other belongings were on display. It was noted that while one bedroom had been recently redecorated, others required painting and some maintenance (for example, handles were missing from two wardrobes). Two bedrooms were fitted with equipment to aid transfers, if required. One resident had a sound system in their room and was using it to listen an audio book while the inspector was there. Other rooms in the centre included a living room, kitchen and dining room, an activity room, two bathrooms, a utility room and a staff room. Overall the centre was observed to be clean and was decorated in a homely manner with artworks and photographs on display.

The kitchen was observed to be clean, well stocked and well organised. Information was available regarding some residents' dietary needs. At one point during the inspection, a resident came into the kitchen and got themselves a snack. The layout of the kitchen enabled them to complete this task independently. Later when reviewing this resident's file, the inspector saw the plan that had been developed to support this resident to learn this life skill.

Maintenance was required in a number of areas throughout the house. Staff advised that requests had been submitted to address some of these but there was no timeframe for the works to be completed. Areas to be addressed included plastering on some walls, the painting in a number of rooms, a broken radiator cover, a broken blind and torn upholstery on a chair. The self-closing mechanisms on a number of fire doors were also broken. The fire doors in the centre will be discussed further in the 'Quality and safety' section of this report. When walking through the centre, it was also noted that the door to the utility room was locked. This restriction had not

been reported to HIQA (Health Information and Quality Authority), as is required. The person in charge later explained that this was not common practice and would ensure that all staff were aware that it was to remain open.

Following the HIQA inspection of this centre in November 2020, the provider committed to providing a space for residents to accommodate visitors by the end of February 2021. At the time of this inspection, in May 2022, works were due to begin in the coming weeks to install a garden room. This room would be used to welcome visitors and for other activities. The person in charge told the inspector that works were planned to make this room accessible to residents once it was in place. They also outlined other work planned for the garden with the input of the provider's horticultural staff.

When the inspector arrived there were two staff on duty and four residents in the house. One resident was waiting to go to their day service, another was still in bed, and the other two residents were in the living room. One was resting on the couch and the other was watching television. The resident waiting to leave the centre was clearly very keen to attend their day services. Staff provided them with gentle support and reassurance and followed up as to the reason for the delay. All staff support observed during this inspection was kind and respectful. Staff clearly knew the residents well and spoke with the inspector about their preferences regarding food, drinks and activities. The inspector spent time with all four residents at various times during this inspection. The residents were not verbal communicators and appeared comfortable with the inspector being in their home. Residents appeared familiar and at ease with the staff supporting them. Staff had a good understanding of each resident's individual communication styles and appeared to communicate effectively with them.

When speaking with the person in charge they advised that ordinarily a third staff would also be on duty however due to unforeseen circumstances, they were unavailable to work at short notice. The person in charge had arranged for third staff member to work in the centre for part of the day. Two staff worked in the centre overnight remaining awake. There was one nurse working in the centre at all times due to the assessed needs of the residents.

Prior to the COVID-19 pandemic all four residents attended a day service. At the time of this inspection only one had returned to their usual daily activities. Another resident was due to return on a phased basis the following week. Management were continuing to liaise with day services regarding the other two residents' return.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. The centre's complaints log and directory of residents were also reviewed. The inspector also looked at a sample of residents' individual files. These included residents' personal development plans, healthcare and other support plans. Areas for improvement were identified and will be outlined in more detail in

the remainder of this report.

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

Capacity and capability

The findings of this inspection indicated that a greater level of management presence and oversight was required in the centre to ensure that the care and support provided was consistent and delivered to a high standard. Increased oversight was required in areas including staff training and protection against infection. The systems in place did not ensure that the areas for improvement identified in previous HIQA inspections and audits completed by the provider were addressed.

There was a clearly defined management structure in the centre which identified the lines of authority and accountability for all areas of service provision. Staff reported to the person in charge who in turn reported to the person participating in management, who reported to the chief operations officer. At the time of this inspection, the person participating in management was on a period of extended leave. Management informed the inspector that recruitment was underway to fill this position. In the interim, a manager who held this role in other designated centres run by the provider was fulfilling these responsibilities. This member of the management team and the person in charge attended feedback at the close of this inspection.

The person in charge was very knowledgeable about the residents' assessed needs and clearly knew them well. They were also familiar with the day-to-day management of the centre and expressed confidence in the staff team. Since the last inspection of the centre, the remit of the person in charge had increased. They now fulfilled this role for five designated centres in total. Although a clinical nurse manager was also involved in the management of these five centres, they were due to go one extended leave in the coming weeks and had not been physically present in the designated centre for many months. The person in charge advised that they visited the centre every week and were in telephone contact with staff daily. However, they acknowledged that a number of actions from internal audits had not yet been completed. Other management responsibilities, such as implementing the provider's performance management processes with staff, were also not completed in a timely manner. Other findings of this inspection indicated that a greater level of oversight was required in the centre.

An annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as is required by the regulations. These reports were not available in the centre but were

provided by the person in charge when requested. When reviewing these documents it was noted that a number of actions outlined in the December 2021 annual review were repeated in the May 2022 six-monthly visit report. These included the development and maintenance of a training matrix, a review of residents' personal plans and records in the centre, a review and need to document residents' progress in achieving their personal development goals, and a review of both the risk and rights restriction registers. Although a review of the risk and rights restriction registers was underway, all other actions were consistent with the findings of this inspection. In addition, as was identified in the last HIQA (Health Information and Quality Authority) inspection, the annual review did not include consultation with residents or their representatives, as is required by the regulations. A number of other areas of noncompliance with the regulations identified in the last HIQA inspection were again identified on this occasion. These included the absence of a suitable private area to receive a visitor and the need to review the evacuation guidance for staff to ensure all residents could be safely evacuated and supervised at the assembly point.

As outlined in the opening section of this report, the staffing levels in the centre on the day of this inspection were not consistent with the planned roster. The person in charge had arranged at short notice for a third staff to work for part of the day. When reviewing rosters in the centre it was identified that often only two staff were on duty during the day. Management explained that if one resident was staying with relatives, a reduced staffing level was sufficient. This arrangement was not reflected in the centre's statement of purpose, in a risk assessment, or on the planned roster.

The inspector asked to see the training matrix for the staff team so as to assess compliance with the training identified as mandatory in the regulations. This information was not available. The person in charge acknowledged that staff were required to attend a number of mandatory training sessions. They advised that the provider was seeking input from external trainers to address the training backlog which had resulted from the break in in-person training sessions due to the COVID-19 pandemic.

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. A review was required to ensure that all of the information included was accurate and reflected the service provided in the designated centre.

Regulation 15: Staffing

The number of staff working in the centre was not always consistent with the planned roster. This did not pose a medium or high risk to residents' safety due to the number of residents in the centre at those times. Staff personnel files were not reviewed as part of this inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

An updated staffing matrix was not available on the day of inspection. The person in charge inform the inspector that the staff team were not up to date with all of the training identified as mandatory in the regulations.

Judgment: Not compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre, as required by this regulation.

Judgment: Compliant

Regulation 21: Records

This regulation was not inspected in full. The dates that residents who had previously received respite in the centre were discharged / transferred to another designated centre were not recorded. This is a requirement of the regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management arrangements in the centre did not ensure that the service provided was consistent and effectively monitored. A number of actions identified by the provider in the annual review and in unannounced visits to the centre to monitor the safety and quality of care and support provided were not completed and were repeated in consecutive reports. The remit of the person in charge had expanded since the last inspection of the centre resulting in reduced capacity for oversight and follow-up on identified issues. Management were not completing performance management reviews at the frequency outlined in the provider's policy. As was found in the last inspection, the annual review did not provide for consultation with residents and their representatives, the fire evacuation plan in the centre required review, and personal development plans were not in

place or regularly reviewed for all residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review to reflect that a short breaks /respite service was no longer provided in the centre. Other inaccuracies identified included the number of staff working in the centre, the management arrangements in place, and the details provided regarding one resident's day service. More detail was also required regarding the emergency procedures in place.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There had been no complaints since the centre was last inspected. The provider had revised their complaints recording template to include the satisfaction of the complainant, as is required by the regulations. Information regarding the complaints procedures were available, including a document with accessible information developed for residents.

Judgment: Compliant

Quality and safety

The inspector found that residents living in the centre were safe and their healthcare needs were well met. Staff knew the residents well and the support provided was tailored to their individual needs. Areas requiring improvement were identified and are discussed in more detail in this section of the report.

While in the centre, the inspector reviewed a sample of the residents' personal plans. These outlined supports that residents required and provided guidance for staff. What residents liked, disliked and found challenging was clearly documented. Although not all healthcare assessments had been reviewed in the last 12 months, as is required by the regulations, there was evidence that appropriate healthcare was provided to residents in line with their assessed needs. Where a healthcare need had been identified a corresponding healthcare plan who was in place. There was evidence of regular communication and appointments with medical practitioners including specialist consultants, as required. There was also evidence of input from

allied health professionals such as dieticians, speech and language therapists and physiotherapists. Although, some residents were identified as requiring a modified diet, guidance was not available regarding one resident's needs in this area. The guidance for other residents had not been reviewed in the previous 12 months. Some residents in the centre had healthcare conditions that required regular monitoring. This was completed by the staff team with support from community based health services.

Some residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Not all residents in the centre had a current personal development plan. While two residents had been supported to develop clear goals in December 2021 and January 2022, there was no plan, timeframes or person responsible to support the residents to achieve these goals. There was also no review or progress noted in that time. The most recent multidisciplinary review of residents' personal plans available in the centre was dated October 2020. The person in charge advised that a more recent review had taken place however records of these were not available.

When reviewing personal plans it was noted that one resident was monitored hourly by staff overnight. There was no reason documented for this and when asked management were not aware of the reason for this intervention. The person in charge committed to reviewing this routine practice.

Family contact was important to the residents in the centre and this was supported by the staff team. There was also evidence of regular contact between the staff team and residents' relatives. Some residents regularly stayed overnight in their family homes. Relatives of other residents visited the centre to bring them out. It was hoped that relatives may spend more time in the centre once the garden room was in place.

The person in charge advised that records were kept of activities that residents participated in while in the centre and also in their local community. The inspector reviewed these records. Despite a variety of preferred activities, including baking, music, arts and crafts and karaoke, being listed in one resident's file none of these took place in the month of April. Instead the most frequent activities recorded were interaction with staff, relaxing, and spending time in the garden. These activities were also those most frequently recorded for the other residents living in the centre. Aside from spending time with relatives, the only community based activities recorded for residents were walks or drives. Improvement was required to ensure that opportunities provided to residents' to participate in activities were in line with their interests and that supports were available for residents to develop and maintain links with the wider community.

The inspector reviewed some of the systems in place regarding the prevention and control of healthcare associated infections, including COVID-19. As outlined previously, the centre was observed to be clean in many areas on the day of inspection. However, a number of damaged surfaces were observed in the centre. These included torn upholstery on a chair and the couch, the surface of the kitchen table and damage to part of the kitchen counter. As a result it would not be possible

to clean these surfaces effectively. The inspector reviewed the laundry area in the utility room. A system was in place to ensure there was no mixing of items that needed to be washed and clean laundry. However, it was noted that clean mop heads were stored on the floor where the skirting boards required cleaning. There was a sign displayed regarding the use of a colour coded cleaning system where specific coloured cleaning equipment was used in specific areas only so as to prevent cross contamination between areas.

A folder containing information regarding COVID-19 was available in the centre. Although it contained public health guidance, these documents were not up-to-date. A contingency plan was also available in this folder. This required additional information, including guidance specific to the residents living in the centre and the facilities available. Further guidance was also required regarding the staffing arrangements and personal protective equipment (PPE) to be used in the event of a suspected or confirmed case of COVID-19 in the centre.

Although observed wearing PPE and regularly washing their hands, staff practices in the centre were not fully in line with public health and the provider's guidance. For example, one staff member was observed wearing a surgical, rather than respirator mask, when supporting a resident to eat. Another resident was wearing many rings and nail varnish on their hands. This was not consistent with the provider's own infection prevention and control policy.

Systems were in place for the maintenance of the fire detection and alarm system and emergency lighting. The premises was provided with fire safety systems including a fire alarm, emergency lighting and fire extinguishers. The inspector reviewed some of the containment measures in place in the centre. A noticeable gap was evident under the door leading to the kitchen. It was also noted that the self-closing mechanisms on two fire doors were visibly broken, another self-closing mechanism did not fully close the door, and the mechanism on a fourth door did not work. The position of an open safety gate in another doorframe prevented another door from closing. As a result, if required in the event of a fire, at least five fire doors may not act as effective containment measures to prevent the spread of fire and smoke.

The inspector also reviewed evacuation drill records. Eight drills had taken place in the previous 12 months. All records indicated that drills had been completed within a timeframe assessed as safe by the provider. Although drills had been completed with night-time conditions and staffing levels, none had involved all four residents. It was also noted that night-time drills were simulated. Staff explained that this meant that the fire alarm did not sound and that rather than bring residents to a safe location, they were instead brought to the exit doors from the centre. While this demonstrated staff's ability to support residents out of their beds and to an exit, it did not address the possible challenges in two staff supporting four residents to safely evacuate and be safely brought to and supported at an outside assembly point. As was highlighted in the last HIQA inspection of this centre, two of the four residents living in the centre had been assessed as requiring one-to-one supervision to safely evacuate. Residents also had support and supervision needs at the assembly point. Two residents required two staff to support them to transfer from

their beds. It was therefore, still unclear how two staff could safely support all four residents to evacuate the centre and be brought to safe locations, as is required by the regulations. The person in charge committed to completing a drill involving all four residents at the next available opportunity and to ensuring an evacuation procedure, reflective of all residents' assessed needs, was available in the centre.

Regulation 11: Visits

As identified in the last inspection, a suitable area was not available to residents to receive visitors. Management informed the inspector that work was due to commence in the coming weeks to build a standalone room in the garden area to facilitate visits and other activities.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents had access to some facilities for occupation and recreation. The centre had its own car which facilitated community based activities. However a review of activity records maintained in the centre indicated that the opportunities provided to residents were not in line with their interests and did not support them to develop and maintain links with their community. At the time of this inspection not all residents had a returned to the same level of attendance at day services as prior to the pandemic. This was consistent with one resident's wishes but not others'.

Judgment: Substantially compliant

Regulation 17: Premises

Parts of the centre required maintenance. These included walls that required replastering and painting, and a broken radiator cover and blind that required either repair or replacement. Requests had been sent to address some of the items identified in the course of this inspection. However, not all had been previously identified and there was no timeline for the requested works to be completed. Although observed to be clean overall, there were cobwebs in one room in the centre and the skirting boards and the utility area required cleaning.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A review of the risk register was underway at the time of this inspection. The risk of reduced staffing levels at times when not all four residents were in the centre had not been assessed.

Judgment: Substantially compliant

Regulation 27: Protection against infection

A folder of COVID-19 documents was available in the centre. However this did not include the most up to date guidance and information from public health or the provider. The COVID-19 contingency plan required review to ensure that it was specific to this centre and the residents' individual needs. One staff member was observed wearing a surgical mask when supporting a resident with personal care. This was not consistent with current public health guidance. Another staff was observed wearing rings and nail polish. This was not consistent with the provider's policy. While observed to be clean overall, a number of damaged surfaces were observed in the centre. As a result of this damage, it would not be possible to clean them effectively. It was also noted that although it had been cleaned, cleaning equipment was not stored in a clean environment.

Judgment: Not compliant

Regulation 28: Fire precautions

The self-closing mechanisms on at least four doors did not work effectively. The position of an open gate prevented one fire door from closing. A large gap was evident under the fire door installed in the kitchen, a high risk area for fire. As a result, if required these containment measures would not prove effective in the event of a fire. Although evacuation drills in night time conditions had been completed, they did not involve all four residents of the centre and did not demonstrate that arrangements were in place to bring all persons to safe locations, as is required by the regulations. Residents' personal emergency evacuation plans (PEEPs) also required review.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Although there was guidance for staff regarding the support needs of residents, not all documents in residents' personal plans had been reviewed in the last 12 months, as is required by the regulations. In some instances documents had been reviewed but were not updated to reflect changes. The most recent multidisciplinary reviews of residents' personal plans were not available in the centre. There was no personal development plan in place for one resident. Although personal development goals had been identified for other residents, there was no plan in place or person responsible to support residents in achieving these goals. At the time of inspection there had been no review or progress noted in the five / six months since the goals were first identified. Allied health recommendations were not available for one resident assessed as requiring a modified diet.

Judgment: Not compliant

Regulation 6: Health care

Overall there was evidence that residents' healthcare needs were well met in the centre. Residents were supported to attend medical appointments in line with their assessed needs. Input from community based services and specialist consultants was also documented.

Judgment: Compliant

Regulation 9: Residents' rights

Staff were observed to be respectful of each resident's privacy and dignity. However it was identified that one resident was checked on hourly by staff at night. Management were not aware of a clinical need for this practice and committed to reviewing it.

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	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 16 OSV-0003292

Inspection ID: MON-0032270

Date of inspection: 18/05/2022

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: Staffing has been addressed in a revised Statement of Purpose and function completed 24/06/2022. Risk assessment regarding staffing was added to the Site specific risk register for the designated centre on 26/05/2022.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training matrix to reflect current training needs will be updated by the Person in Charge by the 09/07/2022. The Registered Provider will ensure that all staff will be supported to attend mandatory training furthermore, the Registered Provider is currently exploring options with external Training companies with the possibility of them facilitating mandatory training programs for members of staff. While awaiting confirmation of training dates for mandatory training staff will continue to participate in online and face to face training provided by the organization where possible and continue to complete relevant training courses on hseland. A full training plan will be in place by 31/10/2022.	
Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records: The dates that residents who had previously received respite were discharge have been recorded and all paperwork pertaining to previous respite attendees have been sent to Client administration for filing. Completed 20/05/2022	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Registered Provider shall make every effort to ensure that governance and management in the centre can provide a service that is consistent and effectively monitored. The PIC who is also a Clinical Nurse manager 2 is available WTE of 0.25. CNM1 is currently on extended leave and recruitment for a panel of CNM1 for the organization has begun. The PIC is in daily contact with the centre and is available by telephone throughout the working week. PIC spends an average of 1 working day (8hours per week) onsite or more if required. During this time the PIC will ensure that all action plans from 6 monthly, annual review and HIQA compliance plan are actively worked on and that consultation from residents' family/representatives is appropriately sought for annual review moving forward. A schedule for performance management reviews is in place to commence on 04/07/2022 and be completed by 13/08/2022.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Statement of purpose and function was reviewed to reflect that short breaks are no longer provided in the designated centre. Other changes made during review of Statement of purpose were, number of staff working in centre, management arrangements in place and further detail has been provide regarding residents current day service attendance.	

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
The visitors room was installed in the garden of the designated centre on the 1st and 2nd of June. We are currently awaiting outside area to be provided with an appropriate pathway and surrounding area of same (contractors employed and lined up for works). Garden works will commence once construction work is completed and it is proposed that the visitors room and surrounding area will be functional and appropriately decorated by 31/07/2022.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Opportunities for activities of choice providing links to community and known to be enjoyed by the residents are provided throughout each week and are now appropriately documented in records of activities held in personal plans.

Two residents have returned to day services, one resident is returning on 30/06/2022 and the fourth resident will return one day per week as per previous routine on week beginning 04/07/2022.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Cleaning issues were addressed on the day of inspection – completed 18/05/2022.

Internal and external cleaning completed 22/06/2022.

Pemac maintenance request have gone in for all home improvements identified and are due to be completed in full by 20/08/2022.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Review of risk register is completed and risk assessment regarding reduced staffing levels at times when not all four residents are in the centre was added to the register during this review. Completed on 26/05/2022.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Storage of cleaning equipment was addressed on the day of inspection – completed 18/05/2022.
Damaged surfaces have been repaired and a replaced where required.
Completed 22/06/2022.

Hand hygiene assessments continue to be carried out monthly and PIC continues to remind staff regarding rings and nail varnish and local policy re:same.

Staff are currently following most recent HPSC guidelines regarding mask wearing.

Covid -19 contingency plan is currently under review and will be completed by 07/07/2022.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All self-closing mechanisms on fire doors have been repaired or replace and are now in working order. The gap between the floor and the fire door leading into the kitchen has been decreased by a competent person.
All residents PEEPs have been reviewed.

A fire drill has been carried out with all four residents present on 19/06/2022. Although it

was carried out during day time hours it was carried out in night time conditions using night time staffing allocation only (2 staff). All four residents were evacuated to a safe location (assembly point. This drill was observed by PIC and a new evacuation plan has been developed as a result of same. All four residents were safely evacuated in 3 minutes and 45 seconds.

Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: A schedule for regular review of personal plans has been developed and is available in the designated centre. Most recent MDT review records are in all personal plans since the day of the inspection. A PCP has been scheduled for the resident that did not have an updated version at the time of inspection. All personal plans including PCPs and goal setting will be completed by 31/08/2022 and reviewed on an ongoing basis. Allied health recommendations are now on site for all residents.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Resident that was being checked hourly by night without a clinical rational for same is no longer being checked as frequently. This practice ceased on the night of the inspection 18/05/2022.	

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 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident; a suitable private area, which is not the resident's room, is available to a resident in which to receive a visitor if required.	Substantially Compliant	Yellow	31/07/2022
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	23/05/2022
Regulation 13(2)(c)	The registered provider shall provide the following for	Substantially Compliant	Yellow	04/06/2022

	residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.			
Regulation 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Substantially Compliant	Yellow	08/07/2022
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	24/06/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/10/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	20/08/2022

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	20/08/2022
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.	Substantially Compliant	Yellow	20/05/2022
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.	Substantially Compliant	Yellow	24/06/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	24/06/2022

Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	23/09/2022
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	13/08/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	26/05/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare	Not Compliant	Orange	07/07/2022

	associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	24/06/2022
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	24/06/2022
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	19/06/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	24/06/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the	Substantially Compliant	Yellow	19/06/2022

	event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	24/06/2022
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/08/2022
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	31/08/2022
Regulation 05(6)(a)	The person in charge shall	Not Compliant	Orange	31/08/2022

	ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.			
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 changes in circumstances and new developments.	Substantially Compliant	Yellow	31/08/2022
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	31/08/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not	Substantially Compliant	Yellow	18/05/2022

	limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			