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 14
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	23 May 2023
Centre ID:	OSV-0003293
Fieldwork ID:	MON-0031360

About the designated centre

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

Cork City North 14 is part of a purpose-built housing development located in an urban setting. It is located within walking distance of local shops and facilities. The service provides full-time residential support to eleven female adults with a diagnosis of intellectual disability or autism. The centre is comprised of three floors which are interconnected by stairs. Each resident has their own en-suite bedroom located throughout the designated centre on all floors. Each floor has a kitchen, dining area and living room. Laundry facilities, visiting rooms and staff office are also available. Cork City North 14 can accommodate individuals with a range of medical and physical needs. Residents are supported by nursing and care staff during the day and there are two staff on duty by night in the centre. The multi-disciplinary team are also available to further support residents when required. Residents are supported to access other services such as GP and chiropody as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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 23 May 2023	08:40hrs to 17:50hrs	Caitriona Twomey	Lead
Tuesday 23 May 2023	08:40hrs to 17:50hrs	Laura O'Sullivan	Support

What residents told us and what inspectors observed

Cork City North 14 is part of a purpose-built housing development located on the outskirts of Cork City. The centre was located over three floors which were connected by stairs. Each resident had their own bedroom with an ensuite bathroom. On the ground floor there was a laundry area used by all residents, a staff office, toilet, and two residents' bedrooms. On the first floor there were five residents' bedrooms and a staff changing area. On the second floor there were four residents' bedrooms, a visitors' room which also had an ensuite bathroom, and a storage room. Each floor also had a living room, and a kitchen and dining room. The designated centre was registered to accommodate 11 residents and provided a full-time residential service only.

This designated centre is run by Cope Foundation. Due to concerns in relation to Regulation 23 Governance and management, Regulation 15 Staffing, Regulation 16 Training and staff development, Regulation 5 Individualised assessment and personal plan, and Regulation 9 Residents' rights, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's 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 provider's registered centres. These regulations were reviewed in this inspection and this report will outline the findings found on inspection.

This centre was last inspected on behalf of the Chief Inspector in October 2022. At that time seven 'not compliant' judgements with the regulations were made. This inspection was completed to follow-up on the compliance plan submitted by the provider following that inspection, to assess compliance with other regulations, and to inform the Chief Inspector's response to the provider's application to renew the registration of the centre. While some improvements were noted, it was identified that the provider had not implemented all of the actions outlined in the compliance plan submitted within the timeframes specified by the provider. Other non-compliances with the regulations were also identified. As a result of these findings, the provider entered into escalation procedures with the Chief Inspector regarding this designated centre.

This was an announced inspection completed by two inspectors. On arrival, the inspectors were welcomed in to the centre by a member of the staff team. Inspectors met with two members of the management team and a senior manager also participated in the inspection in the afternoon.

Inspectors briefly met with two residents shortly after they arrived in the centre. These residents were getting ready to leave for work and to attend their day

service. Residents had been prepared for the inspectors' arrival and appeared at ease in their company. Inspectors saw an accessible document advising residents of the purpose of the inspection on display in a communal area of the centre. Management advised that one resident did not wish to be in the centre while the inspectors were there and had chosen to go to Dublin for the day with their keyworker. Inspectors later saw documentation regarding this and saw how staff had supported the resident to plan alternatives for how they would spend their day. This trip was one of the resident's personal goals that they wished to achieve. One resident was spending a few days in their family home, another was unwell in bed, and another was also in bed on the inspectors' arrival and throughout the day when they were in the communal areas of the centre. Of the 11 residents living in the centre, one or both inspectors spent some time with eight of them. Some residents spoke with inspectors at various times throughout the day, telling them about their interests, plans for the day, and experiences of living in the centre.

Residents had many positive things to say about their lives in the centre, with two saying many times how much they loved living there. Staff were universally praised. Residents described staff as fantastic, great, and easy to talk to. Residents said they felt comfortable asking for help and raising any concerns they may have. From the inspectors' observations, it was clear that positive relationships had been developed between staff and residents. Interactions were warm, respectful, and kind. Warm friendships also existed between residents with one observed making a cup of tea for another, and others talking about places that they liked to go together, for example to the cinema or out for a coffee. On the day of the inspection four residents attended a cookery class together with the support of staff. This was one resident's first time going and they were looking forward to this opportunity, and positive about the class on their return. Residents spoke with inspectors about what they had made and appeared to have enjoyed the class. Some residents were offered to go to bingo later that afternoon. Two residents spoke about a group for older adults that they enjoyed attending. One also spoke about a walking group they had joined. One resident spent time during the inspection showing an inspector how to play their favourite game on their electronic tablet.

Residents also outlined some challenges they experienced living in the centre, with one resident saying that they were happy there sometimes but not others. Another also indicated they had a mixed experience before going on to discuss the difficulties they and others experienced living with a peer.

During the October 2022 inspection, one resident had told an inspector that they wished to live somewhere quieter with people of a similar age to themselves. Documents seen showed that they had continued to express this wish in the subsequent seven months. When speaking with the inspector they advised that they still wanted to live elsewhere, in a quieter place, with no stairs. They told an inspector that the person in charge had spoken to them about this and they hoped it would be sorted. This will be discussed in the 'Quality and safety' section of this report.

At the time of the last inspection three residents spoke about their, and others', challenges living with one peer. This was raised again during this inspection, with

one resident who had not previously discussed this matter with inspectors, describing this peer as 'terrible'. Another resident gave the example that they found it difficult to watch television with their peers, saying that although they wanted to spend time with their friends, they 'do their own thing' due to one peer's behaviour. They described feeling 'boxed in'. Inspectors asked if they had ever discussed this with management or made a complaint. They advised that they had and that nothing had happened yet, telling inspectors 'I suppose we have to put up with it'. During the October 2022 inspection, another resident had also told an inspector that nothing had been done about this situation. This ongoing matter will be discussed further later in this report.

In the April 2021 and October 2022 inspections, the provider was found to be not compliant with the regulation regarding staffing. During this inspection, staffing was highlighted to the inspectors by management and residents and remained a significant issue. As was the case in October 2022, some residents expressed concern for the staff and how hard it was for them when there weren't enough staff working in the centre. Staffing shortages were also highlighted by residents and their family members in surveys completed and sent to the provider in January 2023. An inspector reviewed these surveys, as well as the feedback questionnaires for residents and their representatives sent in advance of this announced inspection. 11 questionnaires were completed by residents with staff support.

In the surveys and questionnaires completed staff were praised by both residents and their relatives and described as wonderful, kind and excellent. Positive comments were made regarding the help and support provided to residents, communication with family members, and activities that residents enjoyed. Areas highlighted by residents that they would like to change included the physical premises (requests for a garden, painting, new blinds, curtains and furniture for bedrooms, to display their own art) and activities (would like to go on more day trips, on holidays, staff to take them more places, to do more jobs around the house, and learn to bake / cook). One resident reported that they would like more staff, and another made reference to not liking when people are fighting and wanting everyone to get along. Relatives' feedback regarding areas that could be improved referenced staffing in the centre and activities, especially outings and community-based activities.

When walking throughout the premises, inspectors saw that it was decorated in a homely manner with photographs on display in communal areas and recently received cards on display in the hallway. Fresh flowers were seen in the main kitchen on the ground floor. The centre was well-furnished and residents appeared very comfortable in their surroundings. The centre was observed to be clean and staff were seen cleaning on the day of the inspection. One resident offered to show an inspector their bedroom. This was personalised to their taste and they told the inspector they had chosen the paint colours. Although generally clean, some cobwebs were seen and the seals in the shower in the ensuite bathroom were black in places. The bathroom also required painting. Some improvements had been made to the premises since the last inspection, these included the replacement of kitchen chairs and a new covering placed on the kitchen units. Additional cooking equipment had been provided in the kitchens on the first and second floors which made them

more functional for residents. When leaving the centre inspectors saw residents making, and enjoying, their dinner in the kitchens. Some areas identified as requiring maintenance in October 2022 remained. These included the ensuite bathroom in the visitors' room, the window sill in a living room, and other damaged surfaces throughout the building such as couches in living room areas and visitors' room, and the laundry room counter. As had been found in the April 2021 and October 2022 inspections of the centre, painting was required throughout the centre. As referenced previously, residents had also highlighted the need for painting.

As well as spending time with the residents in the centre and speaking with staff and management, the inspectors also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the two 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. A review of staff rosters indicated ongoing non-compliances with the regulations. Staff training records and the centre's complaints log were also looked at by inspectors. The centre's risk register was reviewed, as were the fire safety, medication management, and infection prevention and control arrangements in the centre. Inspectors also read a sample of residents' individual files and personal plans.

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

Although there was now increased management presence in the centre, the provider was required to significantly improve the governance and management practices implemented in the centre to ensure effective oversight and sustainable and safe delivery of care and support to residents living in this centre.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. Care and nursing staff reported to two clinical nurse managers who worked alternating shifts. They reported to the person in charge. The person in charge reported to the person participating in management of the centre. The person in charge and the managers who reported to them also fulfilled these roles in one other designated centre. At the time of the October 2022 inspection the person in charge was also responsible for a third centre. However, despite this reduction in their remit, their whole-time equivalent hours assigned to this centre had not changed.

Due to the findings of the October 2022 inspection, the provider was issued with an urgent action regarding the governance and management arrangements in the

centre. In their response, the provider committed to the presence of a manager in the designated centre five days per week, and the presence of the person in charge 1.5 days per week. It was outlined in the annual review action plan in December 2022, and in an unannounced visit report completed by a representative of the provider in April 2023, that management staff were unable to fulfil this commitment. This remained the case at the time of this inspection with management reporting that the needs of the other designated centre were a significant barrier to achieving this agreed action. The person participating in management also referenced some infrastructural challenges such as poor telephone reception and limited available working space.

Given the poor findings of the October 2022 inspection, inspectors assessed the implementation of the compliance plan submitted by the provider to address these non-compliances with the regulations. According to the timelines in this plan, all actions should have been completed. Inspectors found that this was not the case. At the time of this inspection, some actions regarding the following regulations remained outstanding – governance and management, staffing, training and staff development, directory of residents, premises, risk management, individualised assessment and personal plan, positive behaviour support, protection, and residents' rights.

The provider had completed an annual review of, and twice per year unannounced visits to assess, the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in December 2022. An unannounced visit had taken place in October 2022 and again in April 2023. It was noted that representatives of the provider had repeatedly, and at times consecutively, identified improvements needed to meet the requirements of certain regulations. These poor findings were also consistent with inspectors' findings during this inspection. An inspector reviewed the action plans developed in response to the findings of these visits. At times it was difficult to assess the provider's progress as actions were not always clearly outlined and many were noted to be 'in progress'. It was also noted that some were incorrectly marked as complete, for example in response to identified gaps in mandatory training for staff, a training matrix was developed and the action marked as complete despite the fact that mandatory training remained outstanding.

The annual review included consultation with the residents, as required by the regulations. While some residents' comments documented in the review were positive, making reference to liking staff and specific activities, others could be seen as complaints. These included that a resident could not go swimming as the centre was short-staffed, the need for more staff, requests to go out more, including in the evenings and at weekends, and comments that residents could not eat meals in peace or watch television together due to a peer's behaviour. None of these comments were subject to the provider's complaints processes, or included in the action plan developed following the annual review. Some of these comments were similar to those reported to inspectors and in the surveys completed by residents and their representatives in January 2023. A staff member had reviewed these surveys but often the resulting actions were that the matter had been escalated to a

member of the management team, without any further documented follow-up.

These findings indicated that there were insufficient responses from the provider to matters requiring improvement as identified to them by residents, their relatives, their own representatives, and inspectors representing the Chief Inspector. This did not provide assurance that the management systems in place in the designated centre ensured that the service provided was safe, appropriate to residents' needs, and effectively monitored, as is required by the regulations.

Despite these shortcomings, it was recognised that management presence had increased in the centre since the last inspection and regular staff meetings were now taking place. Management also advised that they were also implementing the provider's performance policy with one-to-one meetings taking place twice a year.

An inspector reviewed the complaints log maintained in the centre. A staff member had been appointed as a complaints officer. They had completed a review of each of the six complaints made since the last inspection. This review was signed by the person in charge. At the time of this inspection, all complaints were noted to be closed. The satisfaction of the complainants was not recorded for one complaint, although it was noted that the matter had been addressed in full. It was also identified that all documented actions to be completed in response to another complaint had not been completed. Two residents had made complaints about the negative impact one peer's behaviour had on them. In both complaints, it was clear that residents were upset by this behaviour and that it was not an isolated incident. These complaints were noted to be closed however as outlined in the opening section of this report, and as will be outlined in more detail in the next section, this was an ongoing situation in the designated centre.

An inspector reviewed the staffing arrangements in the centre and looked at a sample of the actual and planned rosters. It was identified that staffing levels in the centre were regularly not consistent with residents' assessed needs and the planned roster. As was found in the last two inspections of this centre, it was found that a Monday to Thursday shift from 5PM to 10PM, to provide one-to-one support to one resident was routinely not filled. Another resident was assigned, and separately funded, to have one-to-one staff during the day. Management informed inspectors that this staffing resource was often blended with the centre's staff team. At the time of the last inspection, this resource was routinely not provided and as a result this resident was unable to attend their day service approximately half of the time. According to documents reviewed in the centre, this staffing shortfall had been addressed in March 2023 with two staff in place to provide this support. However, due to the number of staff working, as outlined on the roster, it was not clear from the roster if this resident had received one-to-one support in the week prior to this inspection. From a review of documents, it was also not possible to determine if this had impacted on their attendance at day service as these records were not consistently and accurately completed. Inspectors concluded that the centre continued to have insufficient staffing resources to ensure the effective delivery of care and support to residents, consistent with their assessed needs.

Despite the compliance plan stating that the provider would come into compliance

with the regulation regarding training and staff development by 28 February 2023, a review of the centre's training matrix indicated that a number of staff required training in areas identified as mandatory in the regulations. These included training in relation to safeguarding residents and the prevention, detection and response to abuse, training in the management of behaviour that is challenging including de-escalation and intervention techniques, infection prevention and control. Management advised that there was in-person training scheduled for the rest of the year and staff would be contacted regarding any identified outstanding online training.

An inspector requested to see a copy of the records maintained regarding adverse incidents in the centre. Although it was stated in a site-specific protocol that copies of incident reports were to be kept in the centre, these were not available. Various documents read by inspectors included descriptions of events that described residents being upset and adversely impacted by peers. It was documented that one of these was to be recorded in an incident report by those who had observed the incident, however management acknowledged this had not taken place.

An inspector also reviewed the statement of purpose available in the centre. 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. This document met the majority of the requirements of the regulations. Not all therapeutic services provided to residents were included, for example, access to a nurse prescriber and advanced nurse practitioner. Some inconsistencies were also identified within the document, including the site specific protocol for fire evacuation and access to cleaning services. These were highlighted to management and addressed during the inspection.

Regulation 15: Staffing

A review of rosters indicated that the number of staff working in the centre was regularly not appropriate to the number and assessed needs of the residents. It was also identified that actual rosters were not always accurate. For example, a staff member supporting one resident on a day trip on the day of the inspection was not included on the roster. It was also not possible to determine management presence in the centre from looking at the rosters.

Judgment: Not compliant

Regulation 16: Training and staff development

As was found on the last inspection of this centre, staff did not have timely access to appropriate training, including refresher training, in the areas outlined as

mandatory in the regulations. It was also noted that the recently appointed complaints officer had not received any training to perform this role.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents review required review to ensure that all information included was accurate. As was identified in the last inspection, there were two different admission dates documented for one resident.

Judgment: Substantially compliant

Regulation 23: Governance and management

As was found in the last inspection, the provider had not sufficiently resourced the centre. As identified previously, there were insufficient staffing and management arrangements. The management systems in place did not ensure the service provided was safe, appropriate to residents' needs, or effectively monitored. There was poor oversight in many areas of the service provided including residents' rights, individual assessments and planning, fire safety, risk management procedures and safeguarding. Effective plans had not been put in place to address areas requiring improvement identified during previous inspections completed on behalf of the chief inspector or during unannounced visits to the centre to monitor the safety and quality of care and support provided. The most recent compliance plan submitted to the chief inspector had not been implemented as outlined.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that all of the available therapeutic services provided to residents were included, and that all information included was accurate and consistent throughout the document. These points were addressed during the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of documents in the centre identified a number of adverse incidents that were not notified to the chief inspector. It was also identified that not all environmental restrictions used in the centre were notified, as is required by this regulation.

Judgment: Not compliant

Regulation 34: Complaints procedure

Not all complaints made by residents were subjected to the provider's complaints policy and procedures. The satisfaction of the complainants was not recorded for one complaint, and in another all documented actions to be taken on foot of a complaint were not completed. The provider had not ensured that measures required for improvement in response to all complaints were put in place.

Judgment: Not compliant

Quality and safety

As was found in the last inspection of this centre, the absence of appropriate governance, management and oversight resulted in poor management of risk and insufficient responses to identified non-compliances with the regulations, residents' expressed wishes and assessed needs, and safeguarding concerns.

While residents were positive about many aspects of living in this centre, ongoing issues which negatively impacted on their day-to-day lives had not been addressed by the provider. During the October 2022 inspection of this centre, three residents spoke with an inspector about the challenges they and others experienced living with one resident. In the subsequent compliance plan submitted by the provider, they committed to reviewing the impact of this resident's behaviour on others from a safeguarding perspective. Findings from this inspection indicated that this was not done.

As outlined in the opening section of this report, residents again spoke with inspectors about their negative experiences as a result of this ongoing situation. In the annual review, it was documented that residents said that they could not eat their meals in peace or watch television in the sitting room due to one resident's behaviour. It was also noted in the report written following an unannounced visit to the centre in April 2023 that one resident reported they were 'fed up' and

referenced the noise made by this resident. During that visit, representatives of the provider reported observing one resident crying, another being agitated, and another withdrawing from communal spaces due to the behaviour of the same resident. In complaints made by two residents in November 2022 and April 2023 there was reference to recurrent distress experienced by both residents, with one complaint record outlining that the resident wanted the complaint logged as this was not the first time this peer had caused them upset. Management were very aware of this situation and acknowledged the negative impact it had on the atmosphere in the centre. When reading daily notes, an inspector read a recent account of a resident coming to staff in tears due to the impact of a different resident's behaviour on them. None of these documented incidents had been subject to the provider's safeguarding policy or procedures.

There was no reference to these peer-to-peer incidents in the sample of safeguarding plans reviewed by inspectors. It was not clear from reviewing these plans what measures the provider had put in place to safeguard residents from further similar incidents while living in the centre. When discussed with management, they acknowledged that these plans required review and later advised that this was done on the morning following this inspection. These plans also referenced that each staff member had training in training in the management of behaviour that is challenging including de-escalation and intervention techniques. This was not the case. When reviewing systems in place in the centre to safeguard residents, it was identified that a safeguarding protocol in one resident's personal plan was due for review in 2021. A revised protocol was sent to management on the afternoon of this inspection.

As was identified in the last two inspections completed on behalf of the chief inspector, there continued to be one resident living in the centre on a temporary basis since 2016. Records showed to inspectors indicated that this resident was initially admitted to the centre on an emergency basis with approved funding for their own community-based home. There continued to be no plan in place to support this resident to move to their own home. Since the October 2022 inspection, management had met on one occasion with the housing allocations officer regarding identifying a house for this resident. Despite committing in the compliance plan to reviewing and identifying the support this resident required to move to a permanent living arrangement, the needs of this resident regarding any potential move had not been recently assessed. The document available regarding considerations for a possible move was dated June 2021. There was also no plan or assessment completed regarding the request made by another resident, seven months previously, to move out of the designated centre. Neither resident was in receipt of advocacy services, although enquiries regarding access to an independent advocate had been made on behalf of one.

Management advised that they hoped to re-introduce the role of advocacy champion among the staff team in the designated centre. One resident had completed a course regarding advocacy and management advised that they wished to support the resident to use their skills. There was a notice on display in the centre regarding an advocacy meeting scheduled for the following day. It was a finding of the last inspection that all residents were checked by staff overnight. For the majority of

residents this happened hourly. In their compliance plan, the provider had committed to developing documented rationale for this practice, if this intervention was assessed as necessary. Management acknowledged that the need for this intervention had not been assessed. At the time of this inspection this practice was ongoing. Staff therefore continued to infringe on residents' privacy and dignity in relation to their personal living space.

Each resident had a personal plan. These plans had been subject to a multi-disciplinary review in March 2023. It was noted that residents were not invited to attend these reviews. Some residents had eating, drinking and swallowing difficulties. From the sample reviewed, inspectors saw that residents' needs in this area had been recently assessed and corresponding plans were in place. Copies of these plans were kept in the kitchen, however it was noted that these were not the most recent plans. This was addressed on the day of the inspection by removing the old guidelines from the notice board. A number of residents had been assessed as requiring a behaviour support plan. As was found in the last inspection, not all behaviour support plans had been reviewed in the previous 12 months, as is required by the regulations. For at least one resident, there had been significant changes in their personal circumstances since their plan was last reviewed. At the time of the last inspection, a restrictive procedure was in place for one resident to be implemented as part of how staff responded to incidents of certain behaviours. Since then their behaviour support plan had been reviewed and this restriction was removed. Management advised that a case conference had been convened regarding this resident and reviews arranged with some health and social care professionals. The case conference was ongoing with further meetings to be scheduled.

In addition to the removal of the resident-specific restrictive procedure, a cupboard which was previously locked was seen to be open on the day of inspection. However, inspectors noted that there were locked cupboards in the laundry room and a locked door to a linen store. In addition, at the time of the last inspection, it was identified that some external doors were locked or only opened a small amount for ventilation purposes. This practice had continued in the centre. As these environmental restraints had not been recognised, they had not been subject to the provider's own restrictive practice policy and procedures, or their use reported to the chief inspector as required by the regulations.

An inspector reviewed the centre's risk register. This had been recently reviewed and included one high-rated risk which related to staffing in the centre. As was found on the last inspection, although this risk had been escalated to senior management, there was no documented response from the provider. The recent review had resulted in the reduction of the ratings in a number of risk assessments. These included those related to safeguarding, and peer-to-peer physical and verbal adverse incidents. Given the ongoing documented peer-to-peer issues, and absence of staffing from 5PM - 10PM for one resident, it was not clear why these risk ratings had been reduced. Some individual risk assessments were also found not to be reflective of the control measures and risks present in the centre. For example, one resident had previously not evacuated the centre during fire drills at night. Neither this information, nor the evacuation aids in place for this resident were reflected in

their fire-related risk assessment, which had been assessed overall as a low risk. It was also identified that a number of hazards in the centre had not been risk assessed. These included identified safeguarding risks for one resident, and the low number of staff working in the centre trained to administer medicines.

Two nurses worked in this designated centre, with one rostered to work in the centre from 8AM to 8PM every day. Only one other staff member was trained in the safe administration of medications. By night two care assistants worked in the centre. Therefore there were regularly times when there were no staff working who could administer medicines. No documented guidelines were available to staff regarding who to contact should a resident require medicine at these times. This was addressed during the inspection by the development of a protocol. Notes read by an inspector indicated that a resident recently had to wait over an hour to receive a PRN (medicine used only as the need arises) painkiller as no staff present were trained to administer medicines. An unannounced visit report written in October 2022 documented a situation where due to the absence of a nursing staff, residents were required to go to another designated centre to receive their prescribed medicines.

An inspector reviewed the medication management systems in place in the centre. Overall, there were clear processes in place regarding the ordering, receipt, prescribing, storing, disposal and administration of medicines. When reviewing the storage of medicines, it was identified that the provider maintained emergency stocks of medicines in the centre. It was noted that one medicine was labelled with a resident's name with this had been blacked out. On the day of inspection, staff were unable to inform an inspector when this medicine was prescribed and who it was prescribed by and for what purpose. The inspector was informed that the emergency medication had to be prescribed in a resident's name to allow for supply from the pharmacy. There was no consultation with the resident whose name was on the medicine regarding this practice. It is a requirement of the regulations that the person in charge ensures that medicine which is prescribed is administered to the resident for whom it is prescribed and to no other resident. Management later advised that this medicine would be returned to the pharmacy.

Systems were in place and effective for the maintenance of the fire detection and alarm system, fire fighting equipment, and emergency lighting. Drills had taken place regularly in the previous 12 months. The fire drill records did not include details such as the supposed location of the fire, the exit route taken, or any evacuation aids used. It was observed that despite posters throughout the building and some individual plans advising the use of the nearest fire exit, the fire evacuation routes displayed in the centre required residents and staff to pass one or more fire exits. An evacuation procedure had not been developed to ensure staff and residents were aware of the safest evacuation routes to use given the size and layout of the centre. As referenced previously, fire evacuation aids were in place to support one resident who may not participate in an evacuation at night. It was identified that staff had not received training in the use of these evacuation aids or practiced using them in evacuation drills or at any other time. Specific guidance on the use of these aids was not included in this resident's personal emergency

evacuation plan (PEEP).

An inspector reviewed some of the systems in place regarding the prevention and control of healthcare-associated infections, including COVID-19. The centre was observed to be clean. Supplies of personal protective equipment were available throughout the centre. The provider had a contingency and isolation protocol in place to be implemented in the event of a suspected or confirmed case of COVID-19 or any other transmissible infection. This required review to reflect the actual staffing arrangements in the centre. When reviewing a sample of daily notes, an inspector read that one resident had presented with a sore throat. Notes outlined that there were no COVID-19 antigen tests available in the centre and that the resident had been supported to go to bed. It was not documented if an antigen test was sourced or if the resident isolated from their peers. This response was not in keeping with the provider's guidance. When raised with management by an inspector, they were not aware of this incident.

As referenced in the opening section of this report, despite some improvements, the general upkeep of the designated centre still required improvement. Some areas requiring maintenance identified at the time of the October 2022 inspection remained outstanding. It was stated in the compliance plan submitted following that inspection that outstanding maintenance actions would be addressed by 28 February 2023. It was also stated that the provider's facilities manager would walk through the centre to identify works required. Management advised that this had yet to take place due to scheduling challenges.

Regulation 17: Premises

As was found in the last inspection, the centre was generally clean and was decorated in a homely manner. However, maintenance works, including painting, were required to ensure it and its furnishings were kept in a good state of repair.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The kitchens were well-organised and stocked with nutritious food. There was evidence that choices were offered at mealtimes and that staff were aware of residents' individual mealtime needs. Residents were being supported to learn cooking skills in line with their preferences. Some residents were observed making their own evening meal with staff support. When leaving the centre, inspectors observed groups of residents sitting down to enjoy their meals together.

Judgment: Compliant

Regulation 26: Risk management procedures

As was identified previously, the provider had not outlined additional measures to reduce or mitigate against a high-rated risk. Based on the findings of this inspection, it was not clear why the risk ratings of some assessments had been recently reduced. Some individual risk assessments were not an accurate reflection of the risks posed and controls in place in the centre. Not all hazards in the centre had been risk assessed, including the low number of staff trained to administer medication and the impact of this on the service provided to residents.

Judgment: Not compliant

Regulation 27: Protection against infection

While there were processes, procedures and resources in place to ensure residents were protected from healthcare-associated infections, there was evidence that these procedures had not been followed when a resident presented with symptoms associated with COVID-19. The contingency plan in place also required review to ensure it accurately reflected the staffing resources in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire evacuation procedures in the centre required review to ensure that they were consistent with other fire safety guidance available in the centre. A centre-specific evacuation procedure was required. Residents' personal emergency evacuation plans required review to ensure they reflected all evacuation aids and supports to be used, if required. Staff also required training and practice in the use of these aids.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had ensured residents had access to a pharmacy for the supply of all medicinal products. Medications were stored in a locked press in the

staff office. Effective measures were in place for the receipt, storage and returning of medication. Improvements were required to ensure effective and safe practices were in place for the prescribing of medications for all residents. Improvements were also needed to ensure that the administration of medications was according to residents' assessed needs, including the administration of PRN medications in a timely manner.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

As was identified in the last two inspections, one resident continued to live in the centre on a temporary basis since 2016. There was no plan in place for this resident to move to a permanent living arrangement. Therefore, arrangements were not in place to meet the needs of this resident. Not all plans had been reviewed in the previous 12 months, as is required by the regulations. This included where there had been changes in residents' personal circumstances. Where specific plans had been reviewed, the most recent versions were not available throughout the centre. Residents were not offered the opportunity to participate in the multidisciplinary reviews of their personal plans.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Additional supports had been engaged to identify and alleviate the cause of one resident's behaviour since the last inspection. To date the effectiveness of this plan was inconsistent however work was ongoing. There had been a reduction in some of the restrictive procedures used in the centre. However, as found during the last inspection, not all environmental restraints used in the centre had not been identified as such and had therefore not been subject to the requirements of the provider's own policy. Identified training gaps are referenced in Regulation 16.

Judgment: Substantially compliant

Regulation 8: Protection

Despite a commitment outlined in the compliance plan, the provider had not considered the impact of one resident's behaviour on others from a safeguarding perspective. Safeguarding concerns were ongoing due to the assessed needs of one

resident and residents' incompatibility to live together. A number of documented incidents outlining residents' emotional distress and adverse impact on their usual day-to-day lives had not been subject to the provider's safeguarding procedures. Identified training gaps are referenced in Regulation 16.

Judgment: Not compliant

Regulation 9: Residents' rights

Despite their compliance plan response to the findings of the previous report, the provider had not assessed the need, if any, for nightly checks on residents. This practice remained ongoing. Residents were not consulted about the use of their names to access medicines to be stored as an emergency stock for the centre. Despite first stating that they wished to move out of the centre seven months previously, there was no plan in place or documented actions completed to support a resident with this request. As outlined in Regulations 5 and 15, one resident was not supported to access the residential service or staffing supports that they had been granted funding to receive. No residents in the service were receiving the support of advocacy services.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City North 14 OSV-0003293

Inspection ID: MON-0031360

Date of inspection: 23/05/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Following the HIQA inspection of October 2022, 2 full-time staff and 1 relief staff were allocated to the designated centre. The PIC and Regional Manager continue to identify staff requirements to Human Resources while maintaining service provision with relief and agency staff. One additional staff member has been allocated to the designated centre from July 2023, on their return from statutory leave. In light of the findings of the registered providers six monthly unannounced inspections, the findings of the two most recent HIQA inspections and the organisational Service Improvement Plan review – a fulltime Person in Charge post has been approved and will now be recruited as a matter of urgency. This person will have sole responsibility for CCN 14 as a designated centre. The person in charge will ensure that there is a planned and actual staff rota maintained at all times. This will accurately reflect all staff working in the designated centre and include the Person in Charge / Clinical Nurse Managers attendance.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

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.

Mandatory Safety Intervention Training (SIT), (formerly MAPA), has been booked for all staff requiring two days training. The PIC has allocated staff for training monthly up to December 2023.

The PIC will ensure that additional staff are trained in the Safe Administration of Medicines (SAMS).

The PIC has sought additional fire and safety training for staff.

The PIC in the designated centre will undertake training specific to the role as identified by the PIC:
• HSE Effective Complaints handling training
• HSE Effective Complaints Investigation training
• Your Service Your Say Complaints Handling Guidance for Clinical staff training.

Staff will be facilitated to attend training while also maintaining service provision.

The PIC will ensure that all mandatory training completed will be recorded on the designated centre training matrix.

Training undertaken by staff based on residents assessed needs will also be recorded on the designated centre training matrix.

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
The PIC has corrected the date of admission, confirmed from the residents file, on 25th May 2023.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In light of the findings of the registered providers six monthly unannounced inspections, the findings of the two most recent HIQA inspections and the organisational Service Improvement Plan review – a fulltime Person in Charge post has been approved and will now be recruited as a matter of urgency. This person will have sole responsibility for CCN 14 as a designated centre.

PEEPS will be reviewed specific to each individual residents regarding fire safety. The PIC will meet with the Owner, Facilities Manager and Gendist Fire personnel relating to current fire protocols and PEEPs will reflect any additional controls.

All residents safeguarding plans will be subject to review and updated where necessary. All residents will be considered in terms of whether they require a safeguarding plan in light of concerns / complaints raised by residents.

A permanent work space will be put in place to accommodate the PIC / Clinical Nurse manager on site, full-time.

The PIC and Regional Manager will continue to meet at least fortnightly. A Regulatory Compliance Review and record will be maintained of these meetings, including actions to be undertaken. The Chief Operations Officer will have direct oversight of the review and discuss progress on a monthly basis with the Regional Manager.

The provider commits to a plan to address standards of care and support as identified with the providers own six monthly unannounced visits.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A residents complaint relating to a peers behaviour has been subject to review. An NF06 was submitted post inspection on 6th June 2023.

All future incidents will be reviewed as they occur and notifications will be submitted as per regulatory requirements.

All incidents will be entered on the NIMS and reviewed as part of staff meetings, management meetings and as part of the care planning process.

The PIC will ensure that all restrictive practices will be subject to review, risk assessment and for the impaction on individual residents.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
PIC has instructed all staff on adherence to the registered providers Complaints Policy. This is to include verbal expressions or concerns made by residents.

Residents concerns expressed at Keyworker meetings, Residents Forum or through direct support to be recorded and addressed in line with Complaints Policy.

The PIC will attend training as outlined in Regulation 16 above.

Hearing and facilitating Residents Voices and Complaints will be a standing item on the staff meeting.

PIC has completed on 25/05/2023, the complainant's satisfaction relating to a complaint made.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The PIC will complete a walk through with the Facilities Manager by 30/06/2023.

All outstanding works assessed to be sent for costing approval. Quotes have been sought for replacement furnishings.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC will complete a comprehensive review of the Risk Register including the rationale for risk ratings.

The PIC will review all residents individual risk assessments as per their care plans. This review will be informed by NIMS reports, regulatory notifications, complaints, community notes and records of behavioral issues.

Each identified risk will be reflective of the controls in place. These will include elements noted on inspection – staffing levels / behaviours of concern / fire evacuation / safeguarding / mental health issues.

The PIC will ensure that additional staff are trained in the Safe Administration of Medicines (SAMS) as reflected in Regulation 16. SAMS will be recorded as a current risk on the risk register.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The PIC will review and amend the Contingency Plan to reflect current staff resources.

The PIC will ensure that all staff are familiar with current HPSC guidance.

The PIC will ensure that all staff are knowledgeable of the registered providers IPC policy, infection symptoms, the actions to take to reduce the risk of infection, including testing and isolation.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC is currently reviewing Fire Evacuation Procedures in the designated centre.
• The PIC has sought additional guidance from the RESPOND manager and Facilities manager / Gendist Fire & Safety and a Manual Handling instructor to support residents and staff. PEEP's will be amended to reflect building wide fire and safety protocols as well as evacuation aides.
• Additional staff training has been requested in fire prevention and the use of fire evacuation equipment aides.
• The PIC is supporting all residents to learn new routes of evacuation i.e nearest escape route.
• The PIC has planned monthly fire drills to support residents regarding fire drill evacuations.

• The PIC has requested staff to include fire drill information at resident forum meetings. • The PIC has ensured all staff have completed online fire training.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • The PIC will review local protocols and update where required regarding ordering, storage and returns of medication in line with the organisations medication policy. • The PIC has identified staff who will complete SAMS Training to ensure PRN medication can be given promptly if required. Please see Regulation 16.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • The PPIM and PIC have met the providers Property Manager to highlight the need for a suitable home for an individual going forward. 17/1/2023 o PPIM and PIC have met with Social Work department and finance department to clarify the funding allocation for the individual. 13/6/2023 o PPIM and COO to engage with HSE on up-date and transition plan. • PPIM will support 2 staff to undertake a deep discovery process with the individual over the next 6-8 months in line with article 19 to lead all aspects of her transition to her new home. Beginning the 23/8/2023 • The PIC will ensure that residents are offer and supported to attend their annual review with the multidisciplinary team. • All support plans will be reviewed at least annually or sooner if circumstances require. Most up to date plans will be available on site. • PPIM to facilitate bespoke PCP training with staff teams with a focus lens on the UNCRPD and Positive Social Role development. 7&8/9/2023 o Support plans – individuals will be supported to review their personal goals on the completion of this training. • Case conference held regarding one residents challenges in sharing her home.

Attendees include the Safeguarding DO, PIC, Regional Manager, Psychologist and Social Worker. 7/6/2023 Agreed Actions include the following;
• A compatibility assessment requested, this was up-dated 2/3/2023. Psychologist began engagement with the individual on 6/7/2023 – follow up engagement will take place on the 20/7/2023.
• Request to internal Advocacy (who is familiar to the individual) has been submitted and agreed for engagement with the individual if they so wish. 14/7/2023
• PPIM will support 2 staff to undertake a deep discovery process with two individuals separately over the next 6-8 months to explore their preference for a purposeful day and their long-term goals regarding their home. Beginning the 6/9/2023 (this process will then be reviewed and roll out for all staff and residents).

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC will ensure that all restrictive practices will be subject to review, risk assessment and for the impaction on individual residents.

The PIC will submit all restrictive practices as NF39As before 31st July 2023.

The Registered Provider and PIC will ensure that all restrictive practices are subject to review by the registered providers restrictive practices review committee.

Rights restrictions will be part of part of PIC / Regional Managers meetings.

Mandatory Safety Intervention Training (SIT), (formerly MAPA), has been booked for all staff requiring two days training. The PIC has allocated staff for training monthly up to December 2023.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC has organised a case conference regarding one residents behaviours of concern. Attendees include the Safeguarding DO, PIC, Regional Manager, Psychologist and Social Worker.
• A compatibility assessment has been requested.
• The PIC has requested all staff to report any incident that negatively impacts residents.

• A recording chart developed by PBST, to ascertain the impact on residents or staff of behaviours of concern, is now part of the behavioural management plan in place for one resident.
• All online NIMS entries are accessible as are the outcome of incidents. The cessation of paper copies will be amended in the NIMS protocol for the designated centre.
• The PIC will ensure that reflective learning regarding any incident is recorded and kept on site.
• The PIC is updating safeguarding plans to ensure that all residents are appropriately supported to be safe.
• The PIC will review all safeguarding plans and incidents to determine if previous incidents should be the subject of reporting to the Designated Officer and safeguarding. This review will be completed by 30th September 2023.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• On 13/06/2023 PIC confirmed Nightly Checks risk assessments were completed for all residents in the designated centre.

• Residents now determine the level of checks they are subject to with the exception of 4 residents who are checked relating to existing health needs.

• The PIC will ensure that no residents name will be used to access medicines to be stored as an emergency stock. The practice of emergency stock has ceased.

• The PIC and the organisations Advocacy Officer will support any resident who wishes to explore moving out to another home.

• The regional manager is supporting staffing to train in an SSDL course to prepare residents for future planning in moving to another home. The PIC has identified 4 staff to complete this course.

• The PIC and Regional Manager are developing a plan to support one resident to access the service and staffing supports consistent with the funding allocated for that purpose.

• The PIC and Regional Manager will source advocacy services to support residents in having choice. This will include supporting residents wish to move out of the designated centre.

• A senior member of staff will lead out of advancing the relocation of one resident on foot of their request to live elsewhere.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/11/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	14/06/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Not Compliant	Orange	31/12/2023

	as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2023
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	25/05/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/11/2023
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	15/07/2023
Regulation 26(2)	The registered	Not Compliant	Orange	31/12/2023

	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.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/11/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/07/2023
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures,	Not Compliant	Orange	31/07/2023

	building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/12/2023
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	06/06/2023
Regulation	The person in	Not Compliant	Orange	31/07/2023

31(3)(a)	charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	12/06/2023
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	30/06/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was	Substantially Compliant	Yellow	30/06/2023

	satisfied.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2023
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	31/12/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or	Substantially Compliant	Yellow	31/12/2023

	circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	31/07/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2023
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	30/09/2023
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability	Not Compliant	Orange	31/12/2023

	participates in and consents, with supports where necessary, to decisions about his or her care and support.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/12/2023
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights.	Not Compliant	Orange	31/12/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional	Not Compliant	Orange	31/12/2023

	consultations and personal information.			