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 South 3
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	05 July 2023
Centre ID:	OSV-0003311
Fieldwork ID:	MON-0031624

About the designated centre

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

A residential service for adults with an intellectual, physical disability and/or autism is provided in this designated centre. The centre comprises three detached buildings located beside each other in a housing development. The centre is located close to Cork City and other large suburbs. One building is a single-storey building divided into two houses with an interconnecting keypad door. The remaining two buildings are two-storeys. All three buildings are of a similar design and layout. Each building has two kitchens with adjoining dining and sitting areas, and two smaller sitting rooms. Combined, the three buildings include 31 resident bedrooms. Staff facilities such as offices are also included. The majority of residents live in the centre on a full-time basis. A respite service is provided in one bedroom and another resident lives in the centre on a shared care basis. The designated centre is open and staffed on a full-time basis. The staff team is comprised of nursing and care staff led by a nurse manager and the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	28

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 5 July 2023	09:45hrs to 21:55hrs	Caitriona Twomey	Lead
Wednesday 5 July 2023	09:45hrs to 21:55hrs	Conor Dennehy	Support

What residents told us and what inspectors observed

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 assessments and personal plan and Regulation 9 Residents' rights, the Chief Inspector of Social Services (the chief inspector) 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 on this inspection and the findings will be outlined in this report.

This centre was last inspected on behalf of the chief inspector in May 2022. At that time a significant level of non-compliance with the regulations was identified. This resulted in escalation activity and the decision to issue the provider with a notice of a proposed decision to cancel the registration of the centre. As a result of assurances provided at that time, including the actions outlined in the compliance plan response to that inspection report, the centre remained registered. This inspection was completed to assess the implementation and impact of that compliance plan, and to assess overall regulatory compliance in the centre. The overall findings of this inspection indicate that although the majority of compliance plan was implemented as outlined, significant non-compliances with the regulations remained. These findings will influence the chief inspector's response to the provider's July 2023 application to renew the registration of this centre for another three year period.

This designated centre is located in a residential area on the outskirts of Cork City. It is part of a purpose-built residential complex and is registered to accommodate 31 adults. The centre comprises three buildings located beside each other. The first building is single-storey and contains two separate residences separated by an internal door fitted with keypad locks. Four residents live in each of these houses. The other two buildings are two-storey and have a similar layout, with each having a small living room, and large kitchen, dining and living room, and both upstairs and downstairs bedrooms on each side. Despite this layout, there are no divisions separating one side of the building from the other and residents freely access the entire building. 12 residents may live in one building and 11 in the other.

Inspectors were informed that a respite service was to be offered in one bedroom and that a shared-care service was provided in another bedroom. The respite service had not yet resumed following the COVID-19 pandemic. The resident who stayed in the centre on a shared care basis spent three nights a fortnight there. At the time of this inspection there was one vacancy in the centre. A resident had been

identified to move in and management advised that the transition to living full-time in the centre had begun. This person had visited the centre a number of times, had met with their peers for meals, and had stayed overnight on more than one occasion. The next step was for this resident to stay in the centre on consecutive nights before moving in full-time on 31 July 2023. This plan was reported to be going well and no concerns had been raised by this resident, the current residents of the centre, or staff regarding this move. At the time of this inspection there were 28 residents living in the centre on a full-time basis. Some residents had moved out of the centre since it was last inspected and others had moved in. One resident who had accessed respite in the centre was now a full-time resident. Current residents' ages ranged from 39 to 74 years old. 22 residents were aged 50 or older, with six of these aged between 65 and 74. One or both inspectors had an opportunity to spend time with 23 residents, and also met with a relative of one resident.

This was an announced inspection completed by two inspectors. On arrival of the inspectors were welcomed to the centre by the person in charge and the person participating in management. Inspectors attended an introductory meeting with both of these management staff, and they were available throughout the day to facilitate the inspection. They also attended a feedback meeting held using video conference technology later that week. Following the introductory meeting one inspector went to the single-storey building, while the other was based in the larger buildings.

When in the centre it was noted that a range of building and premises works had been completed since the last inspection. Many areas had been painted, and new flooring and furniture had been provided throughout the centre. The outside areas had also been enhanced. Both residents and staff highlighted the large flower pots, with some residents speaking with inspectors about their involvement in planting and watering the plants. Outdoor tables and chairs were also in place. At the time of the last inspection, parts of the centre had been identified as requiring cleaning. Since then the provider had increased the number of hours that external cleaning staff worked in the centre. Inspectors' observations on the day suggested that this was effective in improving the cleanliness of the centre. The art room located in one building had been redecorated and was observed in use throughout the inspection by a number of residents living in all parts of the centre. There were a number of communal areas in each building. Various posters and notices were on display showing the staff on duty and giving information on topics such as fire safety, complaints, and the Confidential Recipient. Each resident in the centre had their own bedroom, some of these had ensuite bedrooms. When they returned from day service, one resident offered to show their bedroom to an inspector. This was observed to be clean and well-organised. The resident showed the inspector a variety of photos that were on display. These included photographs of friends, family, and a performer they had once met. There were also photos of them when they were younger which they especially enjoyed looking at. In line with their interests, this resident had a radio in their bedroom. The other inspector also saw a resident's bedroom in another part of the centre. This too was noted to be nicely presented, personalised to the resident, and to have sufficient storage facilities available.

10 residents did not attend day services. Seven of these residents lived in the single-

storey building. Many of these residents used wheelchairs. Since the last inspection equipment had been installed to support these residents with transfers. When an inspector arrived in one of the single-storey residences, there were three residents present as one had already left to attend their day service. Two residents were sitting in front of the television. The inspector greeted these residents but neither responded. Staff were seen interacting with these residents in a kind and respectful manner. Within an hour these residents were supported to go for a walk within the grounds of the centre. Following this walk, residents were supported to have a meal, returned to the living room area, and spent some time in bed that afternoon. The third resident spent a lot of time in the smaller living room, where they met with the inspector. This resident was in the company of a staff member at all times throughout this inspection. This had been assessed as a necessary support and was included as a control measure in a falls risk assessment. The inspector had some difficulty in clearly understanding what the resident was saying. Staff supported this interaction, explaining that the resident had said that they were watching television and read the RTE guide. Later, this resident appeared to wish to speak more with the inspector. During this second meeting, staff indicated that the resident wanted to teach the inspector some Irish words. The resident went on to name some animals, including "capall" and "madra". While the inspector was speaking with the staff member, the resident said the names of the three residents they live with. When asked by the inspector if they liked living with their peers, the resident responded "no". When asked if they liked living in their home, they gave the same response. When asked why, the resident did not respond. After this, the resident was supported to the dining-living room for a meal, and later for a walk. The support provided by staff was observed to be warm and good-natured. Towards the end of the inspector's time in this house, the resident who had been at day services returned and very briefly met the inspector. The resident appeared happy and was smiling when they greeted the inspector. They then went to their bedroom.

At one point during the day, two residents from the adjoining residence came into this house for a period of time. One appeared to come over for a cup of tea, while a staff member supported the other resident to use some sensory items. Later in the inspection, the inspector visited the adjoining residence where these residents lived with two others. On their arrival the inspector was invited in by an individual who did not live in the centre. This person lived in an apartment in the same residential complex and said that they visited the house often. Only two of the residents who did live in the house were present at this time. The inspector greeted both of them. One resident communicated verbally and engaged in a joking manner with the inspector and the staff member. This resident then began talking with the person visiting from another part of the campus. They responded very warmly to this visitor. Before the inspector left, they had a chance to meet all four of the residents while they were in the dining-living area. The atmosphere at this time was generally calm with staff observed and overheard to support the residents in a caring manner. It was also noted that staff took great care to ensure that they maintained supervision of residents in line with their assessed needs. The other inspector also spent some time with one resident of this house when they were in another part of the centre. Staff had supported this resident to go to the art room and when there they had come into the dining area where the inspector was reviewing some documents. The resident had a cup of tea with the inspector before returning to the

art room. The support provided by staff at this time was unhurried, respectful, and kind.

Three residents who lived in the larger buildings did not attend day services. On the day of this inspection there was also a fourth resident present during the day. This resident was due to return to their day service the following day. As was referenced in the last inspection report, only one of these buildings was staffed during the day. Therefore two residents spent their days in a neighbouring building. While residents had not reported any concerns about this when asked in May 2022, during this inspection one of the residents involved clearly expressed a wish to remain in their own home. The inspector first met with this resident in a smaller living room where they were knitting. When asked what it was like to live there, the resident told the inspector that where they were was not their home. They said that they would prefer to stay in their own home during the day and also referenced getting on better with the peers who lived with them. They also expressed how much they missed a former member of staff who they mistakenly thought was working in another part of the centre that day. Later, the inspector saw this resident eating their main meal in the smaller living room while their peers ate in the dining area. When asked by staff if there was a reason for this, they advised that this was the resident's preference. The other three residents did not engage in any conversation with the inspector. One was seen at various times throughout the inspection, in various parts of the centre by both inspectors. They walked around the centre independently and appeared at ease and familiar with their surroundings. Another resident was in staff's line of sight at all times. Staff were aware of the importance of this to ensure the resident's safety. This resident appeared very at ease in the centre and was seen laughing and smiling a number of times. They appeared to enjoy being part of small groups where others were chatting and laughing.

One resident returned from their day centre before their peers and was happy to speak with an inspector. This resident was very positive about living in the centre, saying they loved it. They spoke about their involvement in decorating their bedroom and plans they had for more photographs of people important to them. This resident offered to show an inspector the outside areas and also brought them to other buildings in the centre, independently using the keypads in place to access the building where they lived. This resident advised that they didn't mind spending some time in the neighbouring building before staff came on duty.

Later that afternoon the other residents returned from their day services. Inspectors met with residents in all parts of the centre. A number of residents also came to an office area to speak with inspectors. Residents were positive about many aspects of their lives in the centre. A second resident told an inspector that they loved the centre, reporting that they feel safe there and praising the staff. They had told the inspector when they were last in the centre that they wanted to have music lessons. On this occasion they spoke about the lessons they had taken since and their wish to now participate in a music group. This resident and two of their peers had offered to show an inspector their bedrooms and chat more but had gone to participate in a group activity when the inspector returned from accompanying another resident to see their bedroom. One resident indicated that they liked where they lived as it was so big. Another resident told an inspector about a course that they had started in

University College Cork the previous year. The resident said that the course would be finishing later this year but that they had learned about geography and had really enjoyed the participating in the course. The inspector was also informed by this resident that they liked living in this centre which they described as "home". An inspector sat down with another resident and looked through their communication book with them. This outlined the things that were important to, and interested, this resident as well as some support guidelines. The resident appeared to enjoy this conversation. Staff present supported the inspector to ensure they had correctly understood the resident.

Despite this positive feedback, some residents also expressed dissatisfaction when talking to inspectors. As was found previously, residents wanted to go out more and also expressed a wish to do more activities in the centre. A resident expressed that they would like to do baking in the kitchen where they lived. When speaking with another resident they gave a long list of activities that they enjoyed. On further discussion it was identified that these were all day service activities. At that time they could not think of an activity they enjoyed in the centre. Two residents were very specific in what they would like to do mentioning going to Mass, the library, going shopping for groceries, clothes and to the newsagent, and going for coffee and to restaurants. Residents acknowledged that they sometimes got to do these things but not as much as they would like, telling the inspector that there weren't enough staff. When discussing restaurants, one resident said that they had been to a café in a nearby shopping centre but would like to go out in the evenings and to try places in Cork City. When speaking with an inspector, one resident expressed that they were "half afraid" of a peer and said that weekends were more difficult than during the week. This will be discussed in more detail later in this report in reference to the safeguarding measures in place to protect residents.

On the afternoon of this inspection a group dancing activity had been arranged. Management informed the inspectors that a weekly schedule of afternoon group activities was now in place. This schedule had been developed by a visiting staff member. This staff was not employed by the provider. They were working in the centre for three months over the summer and were focused on supporting residents' participation in activities. As well as the afternoon group activities, they also supported residents to participate in other activities, including art and outings, in either smaller groups or on a one-to-one basis. Management advised that this person worked in the centre from Monday to Friday but that their hours may change to facilitate weekend or evening activities. A number of residents living in the centre participated in the group activity on the day of inspection and also spoke positively about other recently started regular activities, including the newspaper club. One staff member advised that although one resident hadn't attended the group activity, they enjoyed going through the accessible newspaper on a one-to-one basis with staff.

It was identified in the last inspection of this centre that the number and skill mix of staff was not appropriate to the number and assessed needs of the residents living in the centre. Since then the provider had put a waking night staff in one house. Other than that, staffing levels remained the same in the centre. As will be outlined in the next section, findings of this inspection indicated that the staffing levels in the

centre remained inappropriate to meet residents' needs.

As this inspection was announced, feedback questionnaires for residents and their representatives had been sent in advance of the inspection. Ten were completed and returned to the inspectors. Six had been completed by relatives and four by staff. In some of these residents' participation in filling out the questionnaires was clearly outlined.These included some very positive feedback with one respondent describing the centre as "excellent" and others stating that there was nothing they would change. One respondent referenced improvements, stating that the centre was "much better". Staff were praised and described as helpful, friendly, lovely, kind and supportive. One respondent referenced that staff needed additional support, and it was stated in another that the centre was "obviously understaffed" and had been "for years". The importance of familiar staff was referenced in two questionnaires. Many respondents referenced activities they enjoyed, as well as others they would like to do more, both while in the centre and in their local community. It was also documented that residents' clothes were sometimes mixed up with others. Inspectors met with a relative of one resident. They had submitted a complaint since the centre was last inspected and advised that the points expressed in their complaint remained unresolved to their satisfaction. This feedback informed the inspection process.

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

Capacity and capability

It was evident that a number of governance and oversight systems had been implemented and revised in the designated centre in the 14 months since it was last inspected on behalf of the chief inspector. The provider had also implemented the compliance plan submitted in response to the findings of that inspection. Despite these actions, findings on the day of this inspection indicated that the centre was still not meeting the requirements of the regulations.

At the time of the May 2022 inspection, the provider was issued with an urgent action regarding the governance and management arrangements in this centre. On the day of this inspection there were clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. There were clearly outlined reporting structures for each house in the centre. Care and nursing staff reported to a nurse manager. This post was vacant at the time of the last inspection. This manager reported to the person in charge, who reported to the person participating in management. Staff spoken with were positive about the availability of management support and their presence in the centre. The nurse manager and person in charge worked only in this centre and were based there.

The person in charge was fully supernumerary. The nurse manager was also allocated some supernumerary hours, however it was not always possible to facilitate these hours as they were required to cover staffing vacancies due to leave. Since the last inspection, team meetings had been re-established and records reviewed indicated that they took place regularly. The provider's performance management policy was also being implemented in the centre. The person in charge and person participating in management now met monthly. Following the last inspection these meetings occurred more regularly. The person in charge reported that they felt supported by the provider in their role and outlined that there had been a lot of learning for the management team of the centre in the previous 12 months.

As referenced in the opening section of this report, there are apartments located in the same residential complex as this designated centre. At the time of the last inspection, there was a lack of clarity regarding the involvement of the designated centre's management team in these apartments and in the supports of those living there. During the opening meeting, management advised that responsibility for these apartments had now been assigned to another department in the provider's organisation. Staff remained involved in the ordering and receipt of medications only. Management advised that this arrangement worked well.

The provider had introduced systems to support the person in charge and other management staff to have oversight of the care and support provided in the centre. A number of audits were taking place regularly in the centre. An audit schedule had been implemented and included audits into residents' finances, medication practices, infection prevention and control, fire safety, and cleaning. An inspector read some spreadsheets which outlined actions that were devised in response to areas identified as requiring improvement through these audits, and during unannounced six-monthly visits to the centre by representatives of the provider. A review showed that the majority of these actions had been completed, with others in progress. Inspectors concluded that where shortcomings had been identified, management had taken or were in the process of taking appropriate actions to address them. The remaining challenge was that areas requiring improvement were not always identified. On review of one resident's financial records it was identified that the balance noted was incorrect and that this resident regularly did not have any access to their own money while in the centre. The most recent audit completed regarding this resident's finances had not identified the error in the balance and had also incorrectly noted that this resident had access to, and control of, their own money. As will be outlined in the next section, an inspector identified that two fire drills had taken longer than the time assessed as safe by the provider. The person in charge was not aware of this.

The provider had completed an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in October 2022. As was found in the last inspection of this centre, this did not involve consultation with the residents, as is required by the regulations. There was evidence of consultation with some residents' relatives. An unannounced visit had taken place in August 2022 and again in February 2023. As has been identified in other centres operated by this provider,

the action plans developed in response to identified non-compliances with the regulations did not always ensure that the regulatory requirements would be met, for example, in response to findings regarding staffing in the centre the actions were to escalate the risk regarding staff vacancies and to request an update on a funding application. Therefore although the actions may be implemented as outlined, the regulatory non-compliance may remain.

It is a requirement of the regulations that the number and skill mix of staff is appropriate to the number and assessed needs of the residents. It was identified in the last inspection of this centre that it was not compliant with the regulation regarding staffing. In their compliance plan response, the provider stated that the centre was staffed in line with its funding and committed to assessing the needs of the residents living in the centre and, if required, using this information to support an application for additional funding. The provider had completed these actions and the funding request was submitted in October 2022. An inspector read this request which outlined that the provider had assessed that it required one additional whole-time equivalent (WTE) management staff, 6.5 WTE additional nursing staff, 10 WTE additional care assistant staff, and 8 WTE social care workers to meet the needs of the 31 residents in the centre. At the time of this inspection no additional funding for staff had been provided. Despite this, the provider had employed two WTE care assistant posts to provide a waking night staff in the house where 11 residents lived. In light of this application, the provider had clearly assessed that the current staffing levels were not sufficient.

Inspectors also found clear evidence that there were insufficient numbers of staff in this centre. In one of the houses where four residents lived, two staff worked by day. It was highlighted that due to their changing and increasing needs, three of these residents now required additional staff support. Two staff were required to support each of the three residents individually with many aspects of personal care, including those that involved the use of hoists. A recent compatibility assessment conducted in this house concluded that the "the ratio of staff to residents does not reflect the clinical and social needs required by the residents".

As was outlined in the last report, there were regularly two staff supporting 11 or 12 residents in two buildings in this centre. As was the case then, findings on the day of this inspection indicated that this was not sufficient to meet these residents' assessed needs. Residents living in these two houses had a variety of assessed needs, including healthcare needs (such as dementia, epilepsy, swallowing difficulties, diabetes and decreased mobility) that required staff support and supervision. From speaking with residents and staff, and reviewing samples of residents' activity records and personal development plans, it was identified that residents' opportunities to be involved in their local community and activities of their choice were limited by the staff support available. Activities and community participation will be discussed further in the next section of this report. Current staffing levels had also contributed to the use of restrictive practices in parts of the centre. In one house the kitchen was locked when staff were supporting personal care needs, and in another all external doors were now locked to mitigate against the risk of unexplained absences of a resident with dementia. In addition, there were times when staffing in the centre was not provided in line with the current

staffing levels, as outlined in the statement of purpose, for example, records reviewed in one house indicated that there had been 10 days in the previous 3 months where only three staff had been on duty rather than the required four.

At the time of the last inspection a staff training matrix had not been maintained and the provider was issued with an urgent action to ensure there were sufficient numbers of staff trained in the administration of medications, including those prescribed on an emergency basis. The provider had provided assurances regarding this urgent action and in their compliance plan response stated that they would be compliant with the regulation regarding training and staff development by 30 September 2022. An inspector reviewed the current staff training matrix which referenced 39 staff. There was a significant improvement in the number of staff who had recently completed training identified as mandatory in the regulations. There was one notable exception to this. At the time of the last inspection no staff had up to date training in the management of behaviour that is challenging including de-escalation and intervention techniques. At the time of this inspection 73% of the staff team still required this training. This finding posed a risk to residents given that interventions taught in this training were included in the support plans of residents in one house. The inspector saw a training schedule which indicated that two thirds of the required staff would attend this training by the end of September 2023, and the other third by the end of the year.

Prior to this inspection, the inspectors had reviewed the notifications submitted to the chief inspector since the last inspection of this centre. Following the findings of one unannounced visit to the centre, the person in charge had reviewed daily notes and identified a number of alleged safeguarding incidents that had not been notified to the chief inspector. These were then notified but outside of the timeframes specified in the regulations. The regulations also require a quarterly notification outlining any restrictive practices used in a designated centre. Since the last inspection the person in charge had identified and notified the use of a number of restrictive practices that had not been previously recognised. However, while in the centre inspectors identified additional restrictive practices in use that had not been notified, as required. These included locked cupboards that contained food belonging to residents, and others with cleaning supplies.

At the time of the last inspection in May 2022 the provider's complaints policy was not implemented in the centre. At that time only one complaint, dated September 2020, had been documented in the complaints log despite staff reports and numerous documents referencing many more recent complaints made by residents. On review of the complaints log on this occasion, it was noted that 15 complaints had been made since the last inspection. These included complaints made by residents, by staff, and by residents' relatives. Some of these complaints had been originally expressed to representatives of the provider during unannounced visits. Nine of these had been resolved to the satisfaction of the complainant. The six complaints that remained unresolved had been made between May 2022 and May 2023. Many of these complaints referenced the lack of activities for residents on a daily basis, at the weekend, and during breaks from day services. While some referenced community-based activities, others referenced the lack of activities available in the centre and one specifically referenced that the centre was

understaffed. On review of these complaints, it was noted that the measures required for improvement as outlined all referenced the request made for additional staff funding in October 2022. While this was relevant in all cases, it was often the only action outlined where others could have addressed the matter in some way. In some instances, this action did not address other issues outlined in the complaint, for example allocating staff unfamiliar with the residents to work in areas where there were only two staff rostered, poor communication with relatives, and the delegation of duties to staff in the centre. It was outlined in one complaint that, aside from an acknowledgment, five months after a relative had sent a letter of complaint sent to senior management they had not received a response. While it was noted that relatives had been offered meetings with management staff, records indicated that these were offered at least two months after the complaints were made. The documents reviewed indicated that the provider's complaints policy had not been implemented in full regarding these open complaints, with no evidence that complaints had been escalated or updates routinely provided to the complainants.

The provider had been assessed as not compliant with the regulation regarding governance and management in the last three inspections of this centre completed in April 2019, October 2020, and May 2022. Findings on the day of this inspection indicated that despite the substantial amount of work done in the previous 14 months, and improved levels of compliance with some regulations, the centre remained insufficiently resourced. This and other identified shortcomings with the requirements of the regulations as outlined throughout this report, resulted in a continued poor overall level of compliance with the regulations.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of this centre in line with the requirements outlined in this regulation.

Judgment: Compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The registered provider had paid the annual fee outlined in this regulation.

Judgment: Compliant

Regulation 15: Staffing

As was identified in the last inspection of this centre, the number of staff was not appropriate to the number, and assessed needs, of the residents, and the size and layout of the designated centre.The number of staff working in one part of the centre was regularly not in line with the staffing levels outlined in the statement of purpose. In other parts of the centre one or two staff regularly supported 11 or more residents. These staffing levels were not appropriate to these residents' assessed and increasing needs. It was acknowledged that restrictive practices had been implemented due to insufficient staffing.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had committed to coming into compliance with this regulation by the end of September 2022. It was identified that the majority of the staff team required training in the management of behaviour that is challenging including de-escalation and intervention techniques. This posed a risk to residents as interventions taught in this training were included in the support plans of residents living in one house in the centre.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider ensured that insurance against injury to residents was in place.

Judgment: Compliant

Regulation 23: Governance and management

The centre remained insufficiently resourced to ensure the effective delivery of the care and support in accordance with the statement of purpose. A number of systems had been implemented to improve management oversight of the centre, however these were not sufficient to ensure that the service provided was appropriate to residents' needs and consistent. Although increased oversight was demonstrated, in the course of this inspection areas of care and support requiring increased oversight were identified, for example, protection, residents' rights, and fire safety. As was found in the last inspection residents were not consulted as part of the annual

review process.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose 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. It was identified that a minor revision was required in the whole-time equivalent of the staffing one part of the centre. This was addressed during the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all adverse incidents had been notified to the chief inspector within the timelines outlined in this regulation. Not all restrictive procedures used in the centre were notified, as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

Although there was a considerable improvement in the recognition of complaints and the implementation of the provider's policy, this was not consistent. There were six complaints received since the last inspection that had not been resolved to the satisfaction of the complainant. It was not demonstrated that these complaints had been escalated and addressed in line with the provider's own policy.

Judgment: Not compliant

Quality and safety

Inspectors found that there had been some improvement in the quality and safety of care and support provided in the centre since the last inspection. This was most noticeable when reviewing residents' individualised assessments and personal plans,

including those related to healthcare. However, the impact of the under-resourcing of the centre was evident in the compliance levels with some of the other quality and safety regulations, including protection, general welfare and development, and residents' rights. The use of additional environmental restrictions, improved staff training, and additional night staff had reduced many of the risks to residents' physical safety, however the risk of a poor resident experience, as assessed by the provider, remained high. Other areas requiring improvement were also identified.

Inspectors reviewed a sample of the residents' assessments and personal plans. The sample chosen included plans for residents living in each part of the centre. In May 2022, it was identified that a comprehensive assessment of residents' health, personal and social care needs had not been completed on an annual basis, as is required by the regulations. In some cases, these had not been reviewed in three years. Similarly, personal plans had also not been updated annually, as required, or to reflect significant changes in residents' assessed needs. On this occasion, all assessments and personal plans had been updated in the previous 12 months. Personal plans provided guidance on the support to be provided to residents. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and preferences, personal care, healthcare and other person-specific needs such as mealtime support plans. Again in contrast to the findings of the previous inspection, there were records of a multidisciplinary review of each plan.

Residents' healthcare needs were well met in the centre. Residents now had an annual healthcare assessment. Where a healthcare need had been identified a corresponding, recently reviewed healthcare plan was in place. Staff spoken with demonstrated a good knowledge of residents' health needs and how to support them. In May 2022 it was identified that epilepsy support plans were at times not in place, and those that were in place were inaccurate and did not outline all of the supports required. From the sample reviewed during this inspection, there were clear and recently reviewed epilepsy care plans included in residents' personal plans. These outlined residents' assessed needs and required supports in this area. There was evidence of input from, and regular appointments with, medical practitioners including specialist consultants as required. There was also evidence of input from other healthcare professionals, including those qualified in speech and language therapy, occupational therapy and physiotherapy. Five residents living in the centre had a dementia diagnosis. There was evidence that the provider's dementia care team were involved in these residents' supports. Residents were supported to access national screening programmes. When reviewing records relating to two residents it appeared that they had not participated in one such service in a timely manner. This was highlighted to a member of staff who followed up with the relevant service on the day of inspection. It was clarified that one resident's most recent appointment had not been noted in their file. According to this staff member, the second resident had not participated in this two yearly screening service since October 2020. Arrangements were made on the day for a screening kit to be sent to them. A summary document had been developed for each resident to be brought with them should they require a hospital admission. It was identified on one document that a resident's epilepsy diagnosis was not included. Management committed to

addressing this.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Person-centred planning meetings had taken place with residents or their families to identify personal development goals. These outlined what each resident wanted to achieve in the year. While goals were documented for each resident, significant improvement was required in the review and progress of these goals. In the sample reviewed by inspectors, there were a number of goals developed in August and September 2022 where there was no documented progress at all. These included goals to go on a day trip, to go on holiday to a hotel, to visit a relative, or to trial attending a day service. When discussing goals, staff supporting one resident advised that given the needs of this resident they required the use of a particular vehicle. While a licenced driver was available, they were not comfortable driving the vehicle in question. Therefore, the resident had not yet gone of their day trip or holiday. Management were not aware of this barrier. Some plans did note progress made, for example one resident had been supported to go to bingo, a pantomime and meet some friends. However other goals reflected activities that were already part of resident's usual day-to-day activities, such as getting their hair done. It was also noted that it was a goal for one resident to go out for a cup of coffee. This goal was developed in September 2022 and since then, according to records reviewed, the resident had gone for coffee once eight months later. An inspector saw that it was planned for staff to attend training on person-centred planning but this was not yet scheduled.

Multiple staff spoken with raised concerns around their ability to support residents to engage in activities due to the staffing arrangements in the centre. A recent compatibility assessment completed in one house indicated that a resident would express daily that they wanted to be involved in activities but that staff would redirect them as they were not able to facilitate these requests. As outlined in the opening section of this report, on the day of this inspection some residents spoke with inspectors about things they wanted to do more. The need for more opportunities to engage in activities both in the centre and in the community also featured in reports written following unannounced visits to the centre by representatives of the provider, and in unresolved complaints made by residents and their relatives. One complaint referenced a request to go shopping once a week which could not be accommodated. A relative compared the current level of community-based activities available to those available during the national lockdowns imposed at the height of the COVID-19 pandemic, while another described the 'near absence of social activities'.

Records reviewed by inspectors indicated that residents living in parts of the centre with higher staff to resident ratios had more opportunities to participate in activities that they enjoyed and interested them. Examples included having a sing-song, doing puzzles, going out to eat out or to go to the pub, with one staff member speaking with inspectors about recently bringing two residents to the cinema. However, for some residents the majority of their documented activities away from the centre were attending day service, spins or walks. Some staff spoken with indicated that residents went for walks in local parks or to shops but on other occasion these walks

were within the grounds of the centre. Records reviewed for one resident did not include any community-based activity, aside from attending their service, for the months of January, February, March or April 2023. In May they went for a spin on one occasion. The impact of these low levels of activity was referenced in complaints made with some referencing the negative impact noted on residents' mood and overall wellbeing. In the sample of behaviour support plans read by inspectors it was noted that many recommended increased participation in activities as a proactive measure to reduce the likelihood of incidents occurring.

There had been some improvements made in the level of activities available in the centre. As outlined in the opening section, the visiting staff member had devised a schedule of weekly activities and also supported resident's participation in activities during the day. Management had also recruited a volunteer to provide a weekly yoga class which was positively received by many residents. It was hoped to recruit more volunteers, with one interview already scheduled. While these activities were enjoyed by many, it was noted that one activity was available to all 31 residents, some of whom would require staff support to participate, or found being part of a large group challenging. Some residents had also expressed a wish to do things in their own home rather than going to other parts of the centre. The visiting staff member was due to finish working in the centre in the month following this inspection.

The limited opportunities to engage in activities of their choosing significantly impacted on residents' freedom to exercise choice and control in their daily lives. This was recognised and acknowledged by management of this centre. Following the findings of the May 2022 inspection regarding residents' rights, the provider had committed to restarting the monthly residents' meetings which at that time had not taken place for over two years. It was noted that typically between seven and 13 residents attended these meetings. Management advised that they had recognised the limitation of having one meeting for the entire centre and had also started weekly meetings for each house which focused on more day-to-day topics such as meal planning. They had also linked in with the providers' advocacy coordinator to further improve these meetings.

An inspector reviewed the records of the monthly meetings which had taken place consistently since July 2022. Accessible information was often sourced in advance of these meetings to support residents' understanding of the topics to be discussed. Topics included human rights, fairness, and advocacy. Despite the human rights focus it was noted in two meetings that residents had expressed that they were running low on their individual supplies of preferred foods. At these times, residents were advised to contact their families or keyworkers to address this. When the need to contact relatives was discussed with management they advised that some residents' families supported them to go shopping as staff could not. This finding again highlighted the restrictions on residents' abilities to have control over, and make basic, everyday choices for themselves. It was also identified that some residents had limited, if any, access to their own money with one resident regularly having no available money in the centre. As a result, any day-to-day expenses required a request be made to their relatives. Residents' having access to and control over their own finances has been the subject of previous engagement

between the provider and the Chief Inspector with the provider currently undertaking an overall review into this matter. At the feedback meeting to this inspection management advised that plans were now in place to discuss access to this resident's money with their relatives.

In the May 2022 inspection, an inspector read documents which outlined that it was identified in January 2022 that substantial sum of money belonging to a resident could not be accounted for. At that time no follow up actions had been completed regarding this matter. Since then the resident had been reimbursed in full, an investigation had been completed, and additional measures to safeguard residents' finances had been put in place. These were reviewed on inspection and were found to be implemented as outlined.

As outlined previously, in advance of this inspection inspectors reviewed notifications regarding this designated centre since it was last inspected. A number of safeguarding concerns had been notified which outlined peer-to-peer incidents across the centre. It was identified that three residents were repeatedly alleged to cause concern in these incidents. Management advised that one of these residents had been placed on the provider's transfer list. These residents had behaviour support plans in place, however in the case of one resident, this plan did not reference these behaviours directed towards their peers. Management advised that the provider's behaviour support service had only recently become involved in this resident's supports. They also outlined supports this resident received from other health and multidisciplinary professionals, and a plan to arrange a meeting regarding their current and future supports. Where peer-to-peer incidents were reflected in plans, staff spoken with had a good awareness of the supports outlined. Despite this, as highlighted previously, the staffing arrangements in one house had been assessed as contributing to incidents occurring, and some staff had not completed the required training.

One resident had told an inspector that they were "half afraid" of a peer, referencing that this was more the case at weekends, possibly as residents spent more time together in the centre on these days. An inspector reviewed the safeguarding plan in place for this resident. There was reference in this plan to "close supervision, where possible". This was also referenced in the safeguarding plans of other residents living with this peer. Given the staffing levels in this part of the centre and repeated similar incidents, it was assessed that these safeguarding plans were ineffective as they could not be implemented. Inspectors also queried if a reported case of unexplained bruising had been assessed from a safeguarding perspective. It was identified that this had not taken place. At feedback, management advised that all future instances of unexplained bruising would be reviewed with the provider's designated officer.

Safeguarding residents was included on the centre's risk register. However, despite the fact that many safeguarding plans were not effective, it was rated as a medium-level risk. The centre's risk register had been last reviewed in April 2023. Risk assessments reflected additional control measures implemented by the provider, such as the introduction of additional environmental restrictions, and a review completed by a speech and language therapist. It was noted in some instances that

the risk rating was not revised to reflect the impact of these additional controls. It was also noted that individual risk assessments stored in personal plans were not consistent with centre-wide risks regarding the same matter. There was evidence that some high-rated risks had been escalated to the provider's senior management in November 2022 and updates provided in February 2023. All responses related to the centre's staffing levels. However, on the day of inspection it was identified that subsequent high-rated risks, for example, risk of injury due to falls, had not been escalated.

An inspector also examined the fire safety measures in place in parts of the centre. Systems were in place and effective for the maintenance of the fire detection and alarm system, fire fighting equipment, and emergency lighting. An inspector saw that a fire door to one house's utility room, a high-risk area for fire, was not closing fully. Therefore, if required in the event of a fire, it may not prevent the spread of fire and smoke, or provide a safe evacuation route. Fire drills were occurring in the centre which help to ensure that staff and residents are aware of what to do in the event that an evacuation is required. An inspector reviewed fire drills records in two houses and noted that evacuation times were not always recorded. On two occasions, evacuations had taken longer than the time assessed as safe by the provider. Since then the overall fire evacuation plan for the centre had been updated. Staff spoken with demonstrated a good knowledge of this plan. However, no drills had been completed to date to assess if it was effective. It was also identified that at times when an evacuation time had been recorded, not all residents had evacuated the centre.

One resident may choose not to participate in fire drills. Staff spoken with expressed confidence that the resident would evacuate in the event of a real fire and stressed that they would make sure this happened. This resident had a personal emergency evacuation plan (PEEP) which was intended to outline the supports they needed to evacuate. This PEEP did reference that the resident could refuse to evacuate and that if this happened they were to be provided with physical assistance. However, it was not clear what this assistance actually involved. Other residents also required the support of two staff to evacuate but this was not clearly set out in their evacuation plans. Staff who spoke with the inspector were aware which residents needed the support of two staff to evacuate.

Regulation 13: General welfare and development

Although additional on-site group activities had been provided, it was again found that residents were not provided with opportunities to participate in activities in line with their individual preferences, interests and wishes. As was found in the last inspection of this centre, for many residents opportunities to engage in activities outside the centre were very limited, thereby impeding their abilities to develop and maintain links with the wider community..

Judgment: Not compliant

Regulation 17: Premises

Improvements had been made to the premises throughout the centre. The person in charge provided an inspector with a list of works that were completed, in progress, or planned regarding the centre. Those to be completed included bathroom renovations in one house and works to facilitate additional storage. Management advised that these works were planned and the required funding had been approved.

Judgment: Substantially compliant

Regulation 20: Information for residents

This document did not outline how to access any inspection reports on the centre, as is required by this regulations. Additional information was also required regarding the arrangements for residents involvement in the running of the centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The risk register had been recently reviewed and updated to reflect additional control measures implemented by the provider. Some risk assessments required review to ensure that they reflected the current risk posed by identified hazards, and the impact of control measures in place. Not all high-rated risks had been escalated in line with the provider's policy. It was also identified that individual and centre-wide risk assessments were not consistent.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There was not sufficient evidence to demonstrate that the provider could evacuate all persons in the centre and bring them to safe locations. Fire drill records were incomplete. It was not clearly outlined in personal emergency evacuation plans (PEEPs) how residents would be supported to evacuate. As one resident had a

history of not participating in drills this posed a risk to their safety. One fire door, to a high-risk area for fire, required review to ensure that it would be an effective containment measure if required.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Although significant improvement was noted in the area of residents' assessments and plans, non-compliances with this regulation remained. The provider had identified that the centre could not meet the needs of two residents and had placed them on a transfer list. There were no plans in place regarding these moves. A compatibility assessment completed in one house in the centre referenced that the required supports were not in place to meet residents' needs. As identified on the last inspection, one resident's hospital passport did not include all medical diagnoses. Residents were not involved in the multidisciplinary review of their personal plans. Personal development plans were inconsistently reviewed, with no progress noted for a number of goals.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners, and other health and social care professionals as required. There had been a recent query regarding the medical practitioner options available to residents. Management had provided assurance that a medical practitioner of residents' choice would be made available to them. Queries regarding timely access to national screening programmes were addressed on the day of inspection.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required one had a recently reviewed behaviour support plan in place. Staff demonstrated good awareness and understanding of these plans. At the time of this inspection, despite ongoing incidents, one resident's plan provided no guidance regarding peer-to-peer incidents. This resident continued to receive support from the provider's behaviour support team. The finding regarding staff training is addressed in Regulation 16. Not all restrictive practices used in the centre

had been identified or subjected to the provider's restrictive practice policy. These included locked cupboards that included residents' own food, and others used to store chemicals.

Judgment: Substantially compliant

Regulation 8: Protection

There were a number of ongoing safeguarding concerns in the centre at the time of this inspection. During the inspection one resident verbally expressed their fear of a peer. A review of the safeguarding plans in one house indicated that these were not effective in ensuring that residents were protected from abuse. Incidents of unexplained bruising had not been considered, reviewed, or investigated from a safeguarding perspective.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had not ensured that residents had freedom to exercise choice and control in many aspects of their daily lives. There were many examples identified on inspection where residents' requests to engage in activities both within and outside the centre could not be met. Access to community-based activities was not consistent across the centre. Some residents had restricted access to their own food, without any clear rationale for this restriction. Residents' opportunities to participate in everyday experiences such as using their own money to buy things were severely limited while living in this centre. There was an arrangement in place where two retired residents left the house they lived in to spend their day in another house, usually with one other resident, due to the staff roster in place. One of these residents told an inspector that they would prefer to remain at home. This indicated that staffing was not arranged around the needs of the residents.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	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 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City South 3 OSV-0003311

Inspection ID: MON-0031624

Date of inspection: 05/07/2023

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: • The registered provider is committed to ensuring that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the SOP, layout of the centre and in line with the current funding allocation. • An application for additional funding has been submitted to the HSE (17.10.2022) to ensure that the centre is sufficiently staffed to meet the assessed needs of the residents. If the additional funding is sanctioned this will enable the registered provider to increase the WTE staffing in the centre. • The registered provider has sought an emergency meeting with the CHO4 Chief Officer and Head of Disabilities to seek assurances from them that this required funding will be forthcoming. **The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the Care and support of residents in designated centres for persons (children and adults) with disabilities Regulations 2013 as cited in the Health Act 2007 (as amended).**	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Safety intervention training has been booked with schedule in place for the remainder of the year. • Staff supporting residents who require safety interventions will be prioritized to attend this training.	

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 is committed to ensuring that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the SOP, layout of the centre and in line with the current funding allocation.

• An application for additional funding has been submitted to the HSE (17.10.2023) to ensure that the centre is sufficiently staffed to meet the assessed needs of the residents. If the additional funding is sanctioned this will enable the registered provider to increase the WTE staffing in the centre.

• The registered provider has sought an emergency meeting with the CHO4 Chief Officer and Head of Disabilities to seek assurances from them that this required funding will be forthcoming.

• The registered provider is currently in the process of drafting an application to the Authority to separate the designated Centre into two designated Centre's and furthermore, the provider is committed to assigning an additional PIC to enhance governance and oversight of the designated Centre by 30th November.

• The PIC/s will ensure that residents are consulted as part of the annual review of the designated centre going forward.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the Care and support of residents in designated centres for persons (children and adults) with disabilities Regulations 2013 as cited in the Health Act 2007 (as amended).

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• The PIC will ensure that systems are in place for the timely notification of incidents as per regulatory requirements. Local governance protocol is in place to ensure that there is a named person identified to submit notifications in the absence of the PIC.

• All staff will be supported to complete NIMS training on HSE-land to enhance their understanding of the procedures to follow when reporting incidents.

• Local protocol will be developed by the PIC for staff in relation to timely and appropriate reporting and documenting of incidents.

• All restrictive procedures implemented in the centre will be notified in the 3rd quarterly return.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All open complaints in the centre are in relation to staffing shortages / staffing not meeting the assessed needs of the residents in the centre.
• All remaining open complaints have now been escalated by the PIC as per the registered providers complaints policy.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• The providers ability to comply fully with this regulation is entirely dependent on the approval of the funding application for additional staffing resources. Additional resources will ensure that the residents' current and future needs are met by increasing the WTE in the centre. The additional WTE will enable the provision of person-centered supports for residents to live the life they wish within their homes and their community.
• The PIC will continue to ensure in as far as is possible within the current staff allocation, that residents are given as many opportunities as is possible to meet their goals and activities.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the Care and support of residents in designated centres for persons (children and adults) with disabilities Regulations 2013 as cited in the Health Act 2007 (as amended).

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider continues to work through list of works for completion.

• The PIC will liaise with facilities manager in relation to a timeline for the remaining schedule of works to be completed in the designated centre.

Regulation 20: Information for residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 20: Information for residents: • It was identified by PIC after inspection that the version of the resident's guide that had been submitted as part of the registration application was not the current version that was in use within the centre. The version that is currently available to residents includes the required information as per regulation on how to access any inspection reports on the centre, and the arrangements in place for resident's involvement in the running of the centre. • The PIC will ensure that the most up to date version the resident's guide is available to residents in the centre at all times.	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The PIC will ensure that all risk assessments are reviewed in line with organisational policy and that individual risk assessments and risk assessments that form the centres risk register correspond. • The PIC will ensure to escalate high risks to the registered provider as per organisational policy. • The Quality and Safety Advisor will be assigned to assist the PICS with this process.	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Personal emergency evacuation plan for one resident who refuses to partake in	

evacuations has been updated to reflect additional supports required in the event of a fire or other emergency evacuation.
• A local fire committee has been established and meets bi-monthly to ensure that all fire checks are being completed as per schedule, to follow up on maintenance issues relating to fire safety and to ensure that drills and evacuations are being completed as per schedule and records are in place to evidence same.
• Issue with one fire door has been repaired since the inspection.

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 PIC will ensure that all personal plans are reviewed on an ongoing basis and that each resident's personal plan contains accurate and up to date information in relation to their support needs. (personal, social and health needs).
• The PIC will schedule workshops for staff in relation to goal setting and documentation of goals progress.
• The PIC will ensure that residents are involved in the annual multi-disciplinary review of their personal plans.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the Care and support of residents in designated centres for persons (children and adults) with disabilities Regulations 2013 as cited in the Health Act 2007 (as amended).

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 up to date restrictive practice information is included in the third quarterly return.
• Positive behavior support plan for one resident requires review to include guidance for staff in relation to peer to peer incidents. The PIC will liaise with positive behavior support therapist in relation to updating this person's plan to reflect this information for staff.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC has developed a local protocol in relation to unexplained bruising and procedures to follow in the event of these incidences occurring. This will also be added as a standing agenda item in local safety meetings.
• To ensure adequate supervision is maintained, additional staffing is required to implement safeguarding plans successfully. An application for additional funding has been submitted to the HSE (17.10.2022) to ensure that the centre is sufficiently staffed to meet the assessed needs of the residents. If the additional funding is sanctioned this will enable the registered provider to increase the WTE staffing in the centre.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the Care and support of residents in designated centres for persons (children and adults) with disabilities Regulations 2013 as cited in the Health Act 2007 (as amended).

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• PIC will include any restrictions to resident's food items in the next quarterly returns as a rights restriction.
• An application for additional funding has been submitted to the HSE (17.10.2022) to ensure that the centre is sufficiently staffed to meet the assessed needs of the residents. If the additional funding is sanctioned this will enable the registered provider to increase the WTE staffing in the centre.
• The registered provider has sought an emergency meeting with the CHO4 Chief Officer and Head of Disabilities to seek assurances from them that this required funding will be forthcoming.
• Increased staffing and governance will support residents to exercise choice and control of their lives.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the Care and support of residents in designated centres for persons (children and adults) with disabilities Regulations 2013 as cited in the Health Act 2007 (as amended).

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	30/06/2024
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.	Not Compliant	Orange	30/06/2024
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with	Not Compliant	Orange	30/06/2024

	their wishes.			
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	30/06/2024
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	30/11/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/01/2023
Regulation 20(2)(c)	The guide prepared under paragraph (1) shall include arrangements for	Substantially Compliant	Yellow	31/07/2023

	resident involvement in the running of the centre.			
Regulation 20(2)(d)	The guide prepared under paragraph (1) shall include how to access any inspection reports on the centre.	Substantially Compliant	Yellow	31/07/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/11/2023
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	30/06/2024
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	31/08/2023
Regulation 26(2)	The registered provider shall	Substantially Compliant	Yellow	30/09/2023

	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 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/07/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	31/07/2023
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	31/07/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is	Not Compliant	Orange	30/10/2023

	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)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	31/07/2023
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	30/06/2024
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	31/01/2024
Regulation 05(3)	The person in charge shall	Not Compliant	Orange	31/01/2024

	ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
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.	Substantially Compliant	Yellow	31/01/2024
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of	Substantially Compliant	Yellow	31/01/2024

	the plan.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/11/2023
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	30/10/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/07/2023
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	31/07/2023
Regulation 09(2)(b)	The registered provider shall	Not Compliant	Orange	30/06/2024

	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.			
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	30/06/2024