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:	L'Arche Ireland - Cork
Name of provider:	L'Arche Ireland
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	30 March 2023
Centre ID:	OSV-0003421
Fieldwork ID:	MON-0039433

About the designated centre

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

L'Arche Ireland - Cork comprises three two-storey houses located in residential areas in two suburbs of Cork City. A full-time residential service is provided in each house. The centre is registered to provide this service to 14 adults with an intellectual disability. Six residents may live in one house, with four living in the other two. Residents are encouraged and facilitated to participate in activities within the local community as well as to visit other L'Arche homes during the week. There was one full-time person in charge, and one house leader in each house. There were deputy house leaders and care assistants employed in the centre. In addition, each house had a number of volunteer, live-in assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 30 March 2023	10:00hrs to 18:50hrs	Caitriona Twomey	Lead
Thursday 30 March 2023	10:00hrs to 18:40hrs	Deirdre Duggan	Support

What residents told us and what inspectors observed

L'Arche Ireland - Cork comprises three two-storey houses located in residential areas in two suburbs of Cork City. A full-time residential service is provided in each house. The centre is registered to provide this service to 14 adults with an intellectual disability. Six residents may live in one house, with four living in the other two. Residents in each house had their own bedroom. Each house also had a kitchen and dining room (these were two separate rooms in two of the houses), a utility / laundry room, a sitting room, either four or five bedrooms for live-in volunteers, and a staff office.

The staffing complement in centres operated by this provider comprise paid staff and volunteer live-in assistants. Those involved in the management of the centre are paid employees. Volunteers typically live with residents for one year, with some choosing to stay for a shorter or longer period of time. In this centre, where waking night staff had been assessed as required, these shifts were completed by care assistants. There were waking night staff in two of the three houses.

This was an unannounced inspection completed by two inspectors of behalf of the Chief Inspector of Social Services. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspectors and all staff adhered to these throughout the inspection. Both inspectors started the inspection in the house where six residents lived. In the afternoon each inspector visited one of the other houses.

On arrival, the inspectors were greeted by a volunteer live-in assistant. They introduced the inspectors to the five residents who were in the house at the time. A sixth resident was spending time with family members at the time of this inspection. The residents chose to sit with the inspectors in the living room and spoke with them about their experiences of living in the centre. The residents were very welcoming and spoke enthusiastically about living together, their interests, and plans for the day. One resident spoke about their plan to move out of the centre the following year. They appeared happy about this possible move. Others expressed that they would miss their housemate and said they would continue to visit them. Residents were positive when speaking about the staff who worked with them and the volunteers living in the house. They also reported feeling safe. It was noted that some residents were more talkative than others but all appeared to be at ease in the house, with those who spoke less smiling throughout the time spent with inspectors. This group appeared to know each other very well and referenced each other positively throughout the conversation with inspectors. This impromptu meeting came to a natural conclusion as some residents began to get ready to attend their day service. Two of the residents told inspectors that they no longer attended day service and were enjoying their retirement. The person in charge arrived in the house towards the end of this meeting and facilitated the inspection. Inspectors also met with members of the management teams assigned to each house.

Later, when in the other two houses, inspectors had an opportunity to speak and spend time with the residents who lived there. As in the first house, residents were positive about their experiences and the supports they received living in the centre. Residents appeared very much at ease in their surroundings and with the other people present. One resident wished to show an inspector where they kept pet birds in an area behind the house. They spoke with the inspector about their job and the city they were originally from. Another resident appeared curious about the inspector's presence in their home and did not wish for them to see their bedroom. This was respected. When asked about their home one resident responded "I love it here". A resident told an inspector about an important birthday party they had planned. A resident also told the inspector about recently reconnecting with a well known sports figure and their recollections of meeting with this person in the past.

While in all three houses, inspectors had an opportunity to meet with some staff and volunteers. All interactions with residents that inspectors observed and overheard were warm, unhurried, and respectful. The teams appeared to know residents well and were enthusiastic about working in the centre. Staff and volunteers were seen to respond appropriately to residents in line with the support plans in place.

All three houses were observed to be warm, welcoming, and decorated in a homely manner. Art work and residents' photographs were on display in communal areas and parts of one house had been recently painted. Televisions, radios and internet access were available throughout the centre. Accessible information and information specific to each house, such as the dates of birthdays, were also on display. The kitchens in all three houses were well-equipped and stocked with fresh and frozen food. The inspectors saw some residents' bedrooms. These had been personalised to reflect residents' interests. Photographs and residents' preferred items were on display.

It was noticeable that the premises were not maintained to an equal standard. The first house visited by inspectors was spacious and had recently been fitted with a modern kitchen. The other two houses were older buildings and had been identified by the provider in their annual review as requiring 'complete renovation'. This document also referenced the need for immediate repairs in one house. The provider had commissioned a feasibility study regarding the required renovation works and advised that funding options were being explored.

When walking around all three houses, inspectors identified areas requiring maintenance, repair, or replacement. These included damaged skirting boards, chips in kitchen counters, appliances that required replacement handles, and several pieces of furniture with damaged or torn surfaces. It was also noted that some bathroom fittings had rusted, and that seals and grouting were black in places. Some bathroom flooring was heavily stained and some kitchen baseboards were missing. The layout of one house was unsuited to meet the future needs of some residents and a feasibility study had been completed in relation to this. For example, a resident with mobility support needs was accommodated upstairs and some hallways in the centre were not wide enough to accommodate specific mobility equipment, where it was required. While some of these matters had been identified

and work was underway to address them, others had not.

One house, identified by the provider as requiring a complete renovation, was in a poor state of repair and required painting throughout. The inspector observed numerous damaged surfaces throughout this house and holes in the wall of the landing area and in a storage area off the kitchen. The ceiling in one bathroom was marked. A smaller refrigerator used by one resident was rusted in places. Carpet was also observed to be torn in places and cobwebs were seen up high. There was also insufficient storage available with boxes on the floor of the office, and a large storage press used for documentation kept in the living room area. It was also noted that the communal areas were noticeably smaller in this house. Due to the arrangement whereby volunteers lived in the centre with residents, there were eight adults living in this house. Management advised that as part of the feasibility study consideration was to be given to reducing the number of residents who lived in this house.

When in this house, it was observed that a resident routinely placed a wooden item between the door and the door frame of their bedroom, preventing it from closing. It would therefore not be an effective containment measure, if required, in the event of a fire. It was the resident's preference that their door remain open. A closing mechanism that would facilitate this was not in place. This resident liked to store a lot of items in their bedroom resulting in a very cluttered environment. Management advised that there were ongoing efforts to try to address this with the resident. However, despite regularly cleaning and organising this bedroom, it shortly returned to a similar state. An inspector also identified that this bedroom was an inner room. This meant that access to, and exit from, this room was through another room, in this case a utility area where laundry equipment was stored and used. This arrangement increased the risks to both staff and the resident should evacuation be required in the event of a fire. A review of the floor plans of the designated centre also identified two other inner rooms used as bedrooms (one for a resident, the other for a volunteer) in another house. Inspectors also saw the use of extension leads throughout the centre, including in residents' bedrooms and noted that some fire doors throughout the designated centre appeared to be damaged. Given these findings and the associated risks to resident safety, the provider was issued with an urgent action to provide assurances that they were meeting the requirements of Regulation 28: Fire Precautions by ensuring that there were effective fire safety management systems in place, adequate arrangements for maintaining all fire equipment and means of escape, adequate means of escape, and adequate arrangements for containing fires.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. An inspector did review the feedback received from some residents as part of the annual review process. This feedback was positive with residents speaking about their happiness at being able to do more things since the easing of COVID-19 related restrictions. Residents spoke about enjoying summer holidays and gatherings with friends living in other designated centres. Relatives had also completed questionnaires and overall reported a high level of satisfaction with the service provided.

As well as spending time with the residents in the centre and speaking with staff and volunteers, the inspectors also reviewed some documentation. Documents reviewed included the most recent annual review completed in October 2022, 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. Staff training and notifications of adverse incidents to the Chief Inspector were reviewed. Inspectors also looked at a sample of risk assessments, and the arrangements in place regarding residents' personal finances and infection prevention and control. It was identified that significant improvements were required in the areas of fire precautions, premises, and medication management. The inspectors also read a sample of residents' individual files in each house in the centre. These included residents' personal development plans, healthcare, and other support plans. The inspectors' findings will be outlined in more detail in the remainder of this report.

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

Capacity and capability

Some good management practices were seen. The provider adequately staffed the service and it collected information in order to improve the quality of life of residents. Management systems ensured that all audits and reviews as required by the regulations were being conducted. Improvements were required to ensure that the provider's processes and procedures were implemented consistently in each house in the centre. Improvement was also required regarding the submission of notifications of adverse incidents and restrictions used in the centre to the Chief Inspector.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all volunteers and staff were aware of their responsibilities and who they were accountable to. There was a house leader based in each house, and the role of deputy house leader was in place in two of the three houses. Care assistants and volunteers reported to the deputy house leaders (if in place) and house leaders, who reported to the person in charge, who reported to the person participating in management.

The person in charge was employed on a full-time basis and worked in this centre only. They held the necessary skills and qualifications to carry out the role and were both knowledgeable about the residents assessed needs and the day-to-day management of the centre. They also had developed positive relationships with the residents and clearly knew them well. There is a very strong community ethos in the centres operated by this provider and this was very evident throughout this

inspection. Volunteers, staff and the management team appeared to have warm working relationships with each other and the residents living in the centre.

Inspectors were informed that one-to-one supervision meetings took place with each staff member and volunteer regularly, aiming to meet once every six weeks. In addition to the management arrangements in place in the designated centre, the provider also had a locally-based volunteer coordinator to support the volunteers living in this and other Cork-based designated centres operated by the provider. These arrangements provided all working in the centre with regular opportunities to raise any concerns they may have about the quality and safety of the care and support provided to residents, as is required by the regulations.

The inspectors were informed that team meetings took place weekly in each house in the centre. Inspectors reviewed a sample of the minutes of these meetings. It was identified that the recording of meetings was not consistent across the centre. In two houses, meetings were held weekly and detailed minutes were recorded and available. These minutes referenced day-to-day management issues, reflection and learning from any incidents, complaints, safeguarding, and detailed updates regarding each resident. A house leader told one inspector that any staff or volunteer who had not attended a meeting was required to read the minutes. This was especially significant as although handover records were completed, daily notes were not written in any house. In one house, an inspector observed that the meeting minutes were less detailed and did not provide the same level of information regarding the residents. It was also identified that residents' meetings were not taking place at the frequency outlined in the statement of purpose in this house.

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 involved consultation with residents and their representatives, as is required by the regulations. An unannounced visit had taken place in May 2022 and again in December 2022. Where identified, there was evidence that the majority of actions to address areas requiring improvement were being progressed or had been completed. Some outstanding actions included the need for the person in charge to complete additional checks regarding residents' finances, and the maintenance works required throughout the centre.

In advance of this inspection, inspectors reviewed notifications that had been submitted regarding this designated centre to the Chief Inspector. It was noted that three notifications of adverse events had not been sent to the Chief Inspector within the timeframes outlined in the regulations. Another adverse incident had been incorrectly included in quarterly notifications, rather than being notified within three working days, as required. In the course of this inspection, inspectors identified that at least two other adverse events had occurred in the centre which had not been notified to the Chief Inspector, as required by the regulations. Inspectors were assured that these events had been addressed and responded to in line with the provider's own policies and procedures. As such, the identified shortcoming related to the regulatory requirement to notify the Chief Inspector only. It was also identified that a routine environmental restriction used in one house had been

omitted in error from quarterly notifications regarding the use of restraints since early 2022. Other environmental restraints used, such as locking cupboards that contained cleaning products, had also not been notified, as required.

A review of notifications had highlighted possible incompatibilities in the resident groupings in all three houses in the centre. This was also reflected in other documentation read by inspectors in the course of this inspection. When discussed with management, they advised that due to identified incompatibilities, premises issues, residents' changing needs, and vacancies in other local designated centres that the groups of residents who lived together was to be reviewed across the organisation.

An inspector also reviewed staff and volunteer training records regarding areas identified as mandatory in the regulations. It was identified that some required training in the management of behaviour that is challenging including de-escalation and intervention techniques, fire safety, and hand hygiene. Management had a good awareness of the training needs in the centre and had scheduled training in the coming weeks to address these gaps. One person required training in relation to safeguarding residents and the prevention, detection and response to abuse. Management advised that this training would be completed as a priority in the coming days. Training was also planned in first aid, diabetes management, and food hygiene.

There were some staffing vacancies in the centre. As a result agency staff were regularly working by night in one house in the centre. There was also a deputy house leader vacancy in one house. While this did not result in any gaps in the staffing roster, it did have an impact on the governance and management arrangements in this house. This was further compounded by the fact that the team leader based in this house was not currently working full-time hours in the centre. The provider had identified the impact of this vacancy and were trying to recruit a replacement.

Planned and actual staff rotas were available in the centre. As was identified in the last inspection of this centre completed on behalf of the Chief Inspector, improvements were required to ensure that the actual roster clearly indicated the staff and volunteers on duty, including those covering any breaks. Aside from this issue, inspectors assessed that staffing was routinely provided in the centre in line with the staffing levels outlined in the statement of purpose.

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. This document met the majority of the requirements of the regulations. Some revision was required to ensure that the organisational structure in this designated centre was clearly outlined, and to include additional information regarding the emergency procedures in place.

Registration Regulation 8 (1)

The provider had made an application to vary the conditions of registration of the centre in the form determined by the Chief Inspector.

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 14: Persons in charge

The person in charge was employed on a full-time basis, and had the skills, qualifications, and experience necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

As found on the last inspection of this centre, improvements were required to ensure that the actual staffing rosters in the centre were accurately maintained.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had identified training gaps and had scheduled training in the coming weeks to address these shortcomings. Members of the staff team required training in areas identified as mandatory in the regulations including the management of behaviour that is challenging including de-escalation and intervention techniques, fire safety, and safeguarding. Some members of the team also required training in hand hygiene.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were management systems in place to ensure that the service provided was safe and appropriate to residents' needs. The management structure ensured clear lines of authority and accountability. An annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed. There was evidence that where issues had been identified, that the majority of identified actions were completed to address these matters. Management presence in the centre provided all staff with opportunities for management supervision and support. Staff meetings and one-to-one meetings were regularly taking place which provided staff with opportunities to raise any concerns they may have. The provider had identified that the premises were not suitable and in response had commissioned a feasibility study, and was now sourcing funding. Improvements were required to ensure that the provider's processes and procedures were implemented consistently in all three houses in the centre. As outlined throughout this report improvements were required in the fire safety arrangements, implementation of the medication management policy, and the notification of any adverse incidents or restrictions used to the Chief Inspector.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that the organisational structure for this designated centre was clearly outlined. The provider was also asked to include additional information regarding the emergency procedures in the event the centre was uninhabitable.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all adverse incidents or uses of environmental restraints in the designated centre were notified to the Chief Inspector, as required by this regulation. Some other adverse incidents were notified outside of the timeframe specified in this regulation.

Judgment: Not compliant

Quality and safety

From speaking with residents, staff and members of the management team, a review of documentation, and their own observations, inspectors assessed that residents' rights and independence were promoted in this centre. Residents enjoyed living in the centre and were supported to be involved in activities that they enjoyed and interested them. Areas requiring improvement were identified, most notably relating to fire safety, medicines management and premises.

Residents living in this centre had busy, active lives. One resident had a job while others who previously had jobs, had recently decided to retire. Another resident had recently enjoyed work placements and was seeking employment. Many residents attended a day service run by the same provider. Residents spoke with inspectors about upcoming Easter plans and their many varied interests. Residents enjoyed visiting other places and travel, with one resident looking forward to going on a cruise to celebrate an upcoming milestone birthday, and others planning a trip to the Middle East. Residents enjoyed shopping, the theatre, minding their pets, horse riding, baking, swimming, the cinema, current affairs, and puzzles.

Contact with friends and family was important to the residents in the centre and this was supported, where necessary, by the staff team. Residents who wished to had their own mobile phones and electronic tablets. Internet access was available throughout the centre. Relatives were welcome to visit the centre and staff also supported residents to visit their family homes.

Residents were central to any decisions made regarding their lives. As outlined in the opening section, one resident had decided they wished to move to a different model of service the following year and staff were supporting them with this goal. It had been suggested for medical reasons that another resident may benefit from moving from the centre. The provider had supported this resident to access advocacy services and subsequent to this, the resident remained living in their home as they wished. Residents were also supported to be involved in their own supports and healthcare management. One resident with a chronic medical condition was supported to be actively involved in the monitoring and management of their health. Residents were also supported to be as independent as possible in managing their finances. For one resident, although they were supported to go to the bank, they managed all transactions themselves. Another resident travelled independently to and from their day service.

The inspectors reviewed a sample of the residents' assessments and personal plans in each house. These 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 important daily routines. While many of these plans were comprehensive, some gaps were identified. For example one resident was receiving medical treatment for a mental health condition. Despite this, there was no related support plan in place. This resident also required assistance to complete some personal care tasks. There was no personal intimate care plan documented. It was also identified that the meal-time support plan in place for one resident was not consistent with the most recent documented assessment in this area. Some personal plans were also due to be reviewed.

Residents' healthcare needs were well met in the centre. Residents had an annual healthcare assessment. Where a physical healthcare need had been identified a corresponding healthcare plan was in place. The provider employed a nurse who was based locally. Their input was evident when reviewing documentation regarding residents' healthcare needs. There was evidence of input from, and regular appointments with, dentists and medical practitioners, including specialist consultants, as required. There was also evidence of input from other health and social care professionals such as physiotherapists, speech and language therapists, occupational therapists, and opticians. Residents also participated in national screening programmes. A summary document had been developed for each resident to be brought with them should they require a hospital admission.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Personal development goals outlined what each resident wanted to achieve in the year. These goals were personal to the residents and reflected their interests. The person-centred planning and implementation processes were collaborative with input documented from the resident, staff in the designated centre and, where applicable, day service staff and family members. There was evidence that residents were supported to achieve many of their goals. However, it was noted that some goals were repeated in consecutive years. It was not always clearly documented why goals had not been achieved previously.

Of the sample reviewed, residents who required one, had a behaviour support plan in place. These plans were comprehensive and outlined proactive approaches to prevent or reduce the likelihood of incidents occurring, and also response plans to be implemented if required. Staff spoken with were very familiar with these plans and reported that they were effective in supporting residents. There was one notable omission when reviewing one resident's plan. There were documented incidents where one resident had made allegations regarding staff conduct towards them. These matters had been investigated and followed up in line with the provider's safeguarding policies and procedures. It was not documented that an assessment had been completed to identify and alleviate the cause of this behaviour. While a proactive measure was in place to safeguard the resident and those supporting them in specific circumstances, this was not relevant to the documented incidents. The supports required for the resident and the staff team in this area were not documented.

An inspector reviewed a sample of the safeguarding plans in place in the centre. There was evidence that these were kept under regular review. It was also evident

that the provider collaborated regularly with the local safeguarding and protection team. Any safeguarding concerns had been addressed in line with the provider's own policy. As referenced in the previous section of this report, there were some resident incompatibilities in the centre. Inspectors were assured that the provider protected residents from all forms of abuse.

An inspector read a sample of the individualised risk assessments completed for residents. On review it was noted that some ratings were not reflective of the current risk, and that some assessments had not been updated following related events, for example, a recent fall. Management acknowledged these shortcomings and advised that they planned to review the risk assessments in place across the designated centre, and to implement more dynamic risk assessment processes where risks were continuously identified, assessed, reduced, monitored and reviewed.

The inspectors reviewed the medication management processes in place in two houses in the designated centre. The staff spoken with were very knowledgeable about the systems in place. Medicines were stored in a secure, dedicated areas with segregated storage spaces for each resident. Locked medication fridges were available and the temperature was monitored nightly. There were clear processes in place regarding the ordering, receipt, prescribing, storing, disposal and administration of medicines. These were outlined in the provider's policy. When reviewing practices, some inconsistencies with the provider's policy were noted. In both houses, it was identified that the date opened was not always recorded on medicines. In one house, it was also noted that according to one label, a medicine should have been disposed of before the day of inspection. Staff advised that this was a labelling error and would be addressed as a priority. For another resident, it was identified that the administration record for a medicine that was due to have been administered earlier that week had not been signed, in line with the provider's own procedures. The protocol in place for a PRN medicine (a medicine taken only as the need arises) also required review to ensure that the maximum dose to be administered in 24 hours was accurate and consistent throughout the document. Another resident was in the process of having their medicines regularly reviewed, and at times changed, to address a chronic condition. They had seen a medical practitioner regarding this on the day prior to this inspection which had resulted in further prescription changes. While the most recent changes were not yet reflected on the resident's prescription document, other changes made a week previously were also not included. The absence of clear guidance for staff increased the risk of medication errors.

Inspectors also reviewed the arrangements in place regarding a sample of residents' finances in two houses. In one house, one resident independently managed their money, while varying levels of support were provided to others. These residents did not have bank cards and were regularly supported to go to the bank to withdraw money each month. Residents had chosen the amount they wished to withdraw. Records, with staff initials, were kept in the centre of withdrawal slips and receipts for any expenses or items purchased. Any money received or spent was logged, and the balance was regularly checked against the money available. The inspector was informed that no discrepancies had been identified. Residents living in the other

house also had bank accounts in their own name and had consented to any supports they received in managing their finances. Records were also well-maintained.

Records indicated that the majority of staff (including volunteers) had completed training in infection prevention and control (IPC), including hand hygiene. There was an identified IPC lead for the designated centre. Up-to-date public health guidance was available and IPC audits had been completed by a member of the management team. Individualised isolation protocols had been developed for each resident and had been recently reviewed. Supplies of personal protective equipment were available throughout the centre. There was evidence of good management of sharps in one house in the centre.

The designated centre was observed to be clean, however some damaged surfaces were observed on a number of chairs, some other furniture, and on some bathroom shelves and windowsills. Given these damaged surfaces it would not be possible to clean them effectively. The maintenance issues identified by inspectors were outlined in the opening section of this report. Information available indicated that a colour-coded cleaning system was in use in the centre where certain coloured equipment was used in specific areas to reduce the risk of cross contamination. Cloths and other equipment were stored in keeping with this system. Colour-coded mops and other cleaning equipment were also available. The management of laundry in the centre was reviewed. Laundry equipment was stored in well-organised, accessible utility rooms. Some residents were involved in managing their own laundry. There were systems in place to ensure that clean and unclean items were kept separate.

Regulation 12: Personal possessions

Residents had free access to, and retained control, of their possessions. Residents, who wished to, were supported to manage their laundry. Residents had their own bank accounts and, where required, support was provided to manage their financial affairs. There was good record keeping in each house regarding any money belonging to residents that was received or spent while in the centre.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences, interests and wishes. Opportunities were provided to participate in a wide range of activities in the centre and the local community.

Judgment: Compliant

Regulation 17: Premises

It was identified that in one house in the centre there was not suitable storage nor communal rooms of a suitable size to facilitate social and recreational activities, given the number of adults living there. This house was not kept in a good state of repair. Areas requiring maintenance were identified in all three houses in the designated centre. The provider had identified that two houses in the designated centre required a compete renovation. Parts of the centre were not compatible with the mobility needs of those living there.

Judgment: Not compliant

Regulation 18: Food and nutrition

A variety of fresh and frozen food was available to resents in the centre. There was evidence that choices were offered at mealtimes and that staff had a good knowledge of residents' individual dietary needs and preferences. Residents were supported to be involved in shopping and meal preparation in line with their wishes.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk assessments required review to ensure that they were up-to-date and that risk ratings were reflective of the risk posed by the hazards identified in the centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare-associated infections including COVID-19. A COVID-19 contingency and isolation plan specific to each resident was in place. The majority of the staff team had completed training in infection prevention and control, including hand hygiene. The centre was observed to be clean. However there were some damaged surfaces

evident in each house which could not be cleaned effectively.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Three bedrooms in the centre were inner rooms. This meant that exit from these rooms was only possible by passing through another room. This risk was further increased by the assessed needs of one of the residents involved. The placement of an object to prevent a door from closing and the use of electrical extension leads throughout the centre also posed additional fire safety risks. Some fire doors required review by a competent fire professional to ensure that they would be effective containment measures if required in the event of a fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had practices in place relating to the ordering, prescribing, storage, disposal and administration of medicines in the centre. Improvements were required to ensure that these practices were implemented consistently in the centre. Areas requiring improvement included ensuring that all medicines were labelled when opened, that administration records were completed in full in a timely manner, and that residents' prescriptions and associated guidelines were accurate and up-to-date.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs had been completed for each resident. Each resident had a personal plan. Residents were involved in the development and review of their personal development plans. It was identified in some instances that the supports required to meet residents' assessed needs were not always included in their personal plans. These included those assessed with specific medical conditions and who required support with aspects of personal care. One mealtime support plan was not consistent with the most recent assessment. This was addressed during the inspection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were generally well met in the centre. Residents had access to healthcare professionals and health and social care professionals in line with their assessed needs. The finding that not all identified healthcare needs had a corresponding healthcare plan is reflected under Regulation 5.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required one had a recently reviewed an comprehensive behaviour support plan in place. Although it was known that one resident may make allegations regarding staff conduct, this was not reflected in their personal plan and an assessment had not been completed to identify and alleviate the cause of this behaviour. The supports required for the resident and the staff team in this area were not documented. Staff training gaps are reflected in Regulation 16.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had systems in place to protect residents from all forms of abuse. Safeguarding plans were regularly reviewed. Safeguarding concerns were responded to in line with the provider's, and national, policies and procedures. Staff training gaps are reflected in Regulation 16.

Judgment: Compliant

Regulation 9: Residents' rights

The centre was operated in a manner that respected residents' rights. Residents were encouraged and supported to exercise choice, control and independence while living in the centre. Advocacy services had been provided to residents and remained available to them.

Judgment: 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 8 (1)	Compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for L'Arche Ireland - Cork OSV-0003421

Inspection ID: MON-0039433

Date of inspection: 30/03/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: House Leaders are responsible for ensuring that the Planned and Actual Roster is treated as a live document and updated accordingly. The Person in Charge will provide monthly checks on the system which is in place since the 2nd June 2023	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff reminded to complete outstanding training. MAPA completed: 31st May 2023 Safeguarding to be completed by: 7th June 2023 Hand Hygiene to be completed by 7th June 2023 Fire Safety completed by 24th May 2023 All essential training completed by 8th June 2023 The Person in Charge will view the Training Matrix monthly and liaise with the Training Organiser to arrange any necessary training dates for in-house training and reminders for online training. Training to be a regular agenda item on the Person in Charge weekly meeting.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A detailed list of all improvements mentioned throughout the report are in the process of being reviewed with appropriate action plans and timeframes for completion of necessary works. With regards to: Fire Safety Arrangements – Please see letter and action plan dated the 31st May 2023, addressed to Inspector of Social Services (Estates and Fire Safety) regarding the	

Schedule of Works for evacuation and complete renovation of one house.

Please see letter and action plan dated the 2nd June 2023, addressed to Inspector of Social Services (Estates and Fire Safety) regarding the Schedule of Works for renovation to one house.

Implementation of the Medication Management Policy: Please see comment on Regulation 29.
Notification of Incidents: Please see comment on Regulation 31.

A meeting with House Leaders, Person in Charge and service nurse was held on the 17th May 2023 to begin the process of streamlining paperwork.
This system is ongoing and will be reviewed at quarterly meetings with the CEO.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of Purpose updated to include:
- an organizational chart pertaining to Designated Centre 1, L'Arche Cork only.

- Information on alternative accommodation should either a house or the centre become inhabitable. This involves using other accommodation throughout the organization by housing the live in assistants in other available accommodation and using their rooms for the residents in a registered designated centre as being the preferred option. If this is not possible, hotel/rental accommodation will be availed of and the relevant notifications and/or application to vary conditions submitted to the Health Information and Quality Authority.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Incident form updated to include the relevant Notification of Incidents number as a prompt for ensuring the notifications are returned within the necessary timeframe.
Quarterly returns will be checked against previous returns along with referring to practices that are currently in place requiring new or ongoing notification.
NF03s will be submitted for all serious injuries to a resident requiring immediate medical and/or hospital treatment within 3 days of the incident occurring.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Action Plans, relating to schedules of work, has been drawn up to address the need for one house to be renovated and another to be vacated in order for the work to take place. Please refer to letters addressed to the Inspector of Social Services (Estates and Fire Safety) on the 31st May 2023 and 2nd June 2023.

A Health and Safety/Infection Prevention and Control Audit has identified the necessary daily maintenance/infection control tasks that need to be addressed within the risk assessed time period.

Regulation 26: Risk management	Substantially Compliant

procedures	
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: All Risk Assessments have been reviewed to reflect the risk before and after control measures have been put in place.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: Damaged surfaces to be replaced or mended. A Health and Safety/Infection Prevention and Control Audit has identified the necessary daily maintenance/infection control tasks that need to be addressed within the risk assessed time period.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Please see letter and action plan dated the 31st May 2023, addressed to Inspector of Social Services (Estates and Fire Safety) regarding the Schedule of Works for evacuation and complete renovation of one house. Please see letter and action plan dated the 2nd June 2023, addressed to Inspector of Social Services (Estates and Fire Safety) regarding the Schedule of Works for renovation to one house. Premises inspected by competent Fire Assessor on 9th May 2023, following on from a desktop analysis of the properties submitted on the 2nd April 2023. Electrical Leads have been removed with additional sockets installed by a RECI certified electrician. There is an action plan for the replacement of Fire Doors detailed in letters referenced above. Obstructions to the Inner Room were removed by the 4th April and the areas are now Emergency Exit routes.	
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 implementation of the Medication Management Policy will be reviewed with all house leaders and a process for addressing the correct labelling and documentation to be established. System to be improved up through monthly monitoring by the Person in Charge and nurse.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Care plans have been updated with the latest information in relation to specific medical conditions, personal care and dietary requirements.	

A review of the layout and content of Care Plans took place on the 17th May 2023 with the house leaders, person in charge and the service nurse.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: All Positive Behaviour Support Plans are in the process of being updated. Training in management of actual and potential aggression completed by all staff/assistants by the 31st May 2023. A protocol for supporting staff during and after an allegation is currently being drawn up with information being sourced from the relevant employee legislation and a behavioural support organisation.	

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	02/06/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	08/06/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the	Not Compliant	Orange	01/08/2023

	number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	01/08/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	01/08/2023
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.	Substantially Compliant	Yellow	30/06/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	02/06/2023
Regulation 27	The registered provider shall ensure that	Substantially Compliant	Yellow	30/07/2023

	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.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	04/04/2023
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	04/04/2023
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	04/04/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	04/04/2023
Regulation 29(4)(b)	The person in charge shall	Not Compliant	Orange	23/06/2023

	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.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	02/06/2023
Regulation 31(1)(d)	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 serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	30/04/2023
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse	Not Compliant	Orange	30/04/2023

	incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(a)	The person in 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.	Not Compliant	Orange	30/04/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/04/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Substantially Compliant	Yellow	31/05/2023

	to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	13/06/2023