Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	North County Cork 5
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	30 August 2022
Centre ID:	OSV-0003298
Fieldwork ID:	MON-0033387

About the designated centre

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

The designated centre is a large detached bungalow, located on the outskirts of a major rural town. At the time of this inspection, residential services were provided to eight adult residents diagnosed with a moderate to severe intellectual disability. The designated centre is registered for ten residents. The living accommodation comprises four twin bedrooms and two single bedrooms. Two twin bedrooms had single occupancy on the day of inspection. There is a large kitchen and dining area with adjoining food storage and food preparation areas. There is a large living room and a small television room, a laundry room, toilets and two large shower rooms. There is a staff office as well as a smaller office used to store residents' files and paperwork. The designated centre has a well planned and maintained garden with extensive patio and sitting areas. The staff team consists of nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 30 August 2022	09:30hrs to 18:30hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

The designated centre was a detached bungalow on the outskirts of a rural town in County Cork. The centre was registered to accommodate ten residents. There were eight residents living in the centre at the time of this inspection. There were six bedrooms in the centre, four twin and two single bedrooms. Due to the current occupancy level, four residents had their own bedrooms and four shared with one other resident. There was a large, well-equipped kitchen and dining room with adjoining food storage and utility areas. One resident had specific dietary needs and separate storage areas were assigned for their food. Residents had access to a large living room, a smaller living room, a laundry room, toilets and two large shower rooms. There was a staff office as well as a smaller office area / store off the kitchen. When walking around the centre some areas requiring maintenance, repair or replacement were identified. These will be outlined in the 'Quality and safety' section of this report. The designated centre had a well-maintained, large garden with a patio and a number of shaded sitting areas. A part of the garden had been adapted to create a putting green due to one resident's interest in golf.

This was an unannounced inspection. On arrival, the inspector was greeted by a member of staff who introduced them to the person in charge. The person participating in the management of the centre also attended part of the inspection and attended the feedback meeting held by teleconference the following day. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

The centre was observed to be clean, bright and decorated in a homely manner. Photographs were displayed creatively throughout the building. The centre had recently received a gift of a number of artworks and each resident had been supported to choose some and put them up in their bedrooms. Most residents were not verbal communicators and visual supports to aid their understanding were on display throughout the centre. Staff told the inspector that one resident liked to update the visual board that showed who was working that day. There was also a display outlining residents' birthdays. One resident had celebrated a milestone birthday earlier that week and decorations to mark this occasion were on display. It was another resident's birthday later in the week and they were looking forward to their planned celebration.

Residents' bedrooms were personalised to their tastes, with some choosing to have televisions. Shared bedrooms were equipped with a privacy screen which residents chose to use at times. Staff reported that the residents who shared a bedroom were happy to do so and emphasised the fun that two residents in particular had together in this shared arrangement.

The inspector had the opportunity to spend some time with all eight residents living in the centre. All of the residents greeted the inspector, with some choosing to

engage more than others. This was respected. Residents appeared very much at ease in the centre and with the staff support provided. Residents were observed moving freely throughout the centre and engaging in day-to-day activities of their choice. During the inspection residents were watching television, listening to music, spending time in the garden, having a cup of tea with staff, and engaging in some household tasks. One resident appeared distressed early in the inspection and again later in the afternoon. Staff explained that this resident found certain times of the day difficult. No other residents appeared negatively impacted by their presentation at these times. It was clear that warm and positive relationships had been developed between residents and members of the staff team. Staff displayed a very good understanding of each resident's individual communication styles, support needs and personalities. All interactions observed were respectful, unhurried and kind. Residents' independence was encouraged and the staff support provided was tailored to each resident's needs.

There were four staff, in addition to the person in charge, working in the centre during the day. Overnight, two staff worked a waking night shift. As none of the residents living in the centre attended day services, members of the staff team also facilitated opportunities for involvement in activities both in the centre and in the local community. On the day of this inspection residents were supported to go for walks in the garden, listen to music and practise golf. Residents were also supported by staff to access a separate building, located on the grounds, where they had access to arts and crafts supplies and other recreational facilities. Art created by one resident had featured in the provider's 2022 calendar. Staff reported that residents really enjoyed spending time in this building and that several residents went there many times a week. This building was not included in the floor plans and was therefore not part of the designated centre. Its use for other purposes was identified in the course of this inspection and resulted in escalation activity. This will be discussed later in this report.

Some residents clearly had preferred areas where they liked to spend their time. The availability of two living rooms, a large kitchen and dining area, and the garden meant that residents were able to spend time together or alone, in line with their needs and preferences. A number of notifications had been submitted to HIQA (Health Information and Quality Authority) since the last inspection of the centre reporting the occurrence of adverse incidents. Many of these involved the same residents and suggested a possible incompatibility in living together. Staff had a very good understanding of these dynamics and were vigilant about any possible negative interactions. The staffing ratios in place and the high level of staff awareness of these matters were essential to ensure residents were kept safe in the centre.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. The inspector did review the feedback received from some residents' relatives as part of the annual review process. This feedback was all very positive with respondents stating that they were very satisfied with the service provided and felt they were kept informed and up-to-date regarding their relative. The staff team were described as

excellent, very welcoming, always helpful and very supportive.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the 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 was reviewed and was identified as requiring increased oversight. An urgent action was issued regarding this. The centre's complaints log was reviewed and while there was evidence of follow up actions, some complaints had not been closed or escalated in line with the provider's own policy. The centre's COVID-19 contingency plan was read. It was identified that urgent changes were required to this plan. The inspector also looked at a sample of residents' individual files. These included residents' personal development plans, healthcare and other support plans. While comprehensive, areas for improvement were identified and will be outlined in more detail in the remainder of this report.

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

Capacity and capability

The provider needed to improve the overall governance and management in the centre in order to ensure that it was operated in line with the requirements of the Health Act 2007. Although there was evidence of strong leadership in the support provided to residents, additional oversight was required in some areas of the service provided. An urgent action was issued regarding staff training. The centre was staffed by a committed staff team who knew the residents well.

When reviewing the documented COVID-19 contingency and isolation plan, the inspector noted that this plan entailed residents moving to the activity building located on the same site for their period of isolation. As previously outlined this building was not part of the designated centre and was therefore not registered with HIQA. Initial enquiries suggested that this plan had been implemented as outlined and that the provider had potentially carried on the business of a designated centre in an unregistered building, potentially in breach of Section 46 of the Health Act 2007. The implementation of the plan on four separate occasions between 2020 and 2022 was confirmed by the provider following the inspection. As a result, HIQA's escalation procedures were implemented.

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. Care and nursing staff reported to the person in charge, who reported to the person participating in management.

There had been a number of changes to the management arrangements in the centre since the last HIQA inspection in March 2021. A new person in charge was appointed in January 2022. Although replacing a full-time position, initially, due to other management commitments, they dedicated 80% of their working week to this centre. This increased to a full-time commitment at the end of June 2022. Previously, the centre had the support of another manager, who reported to the person in charge, for 40% of the working week. However this position was vacated in January 2022 and had not been replaced to date.

In addition, the centre had experienced two outbreaks of the COVID-19 virus in the previous nine months. These outbreaks involved both staff and residents and required high levels of flexibility and cooperation from management and the staff team to ensure the required staffing levels were maintained. A number of staff were on long-term leave which added to the staffing challenges. While successful in maintaining staffing levels, inevitably there was a negative impact on the management and oversight of the centre as a result. Areas that required increased oversight included staff training, residents' personal plans, the implementation of the provider's own complaints policy and management of documentation in the centre.

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 December 2021 and involved consultation with residents' representatives. However there was no evidence of consultation with the residents, as is required. This has also been a finding in other centres operated by this provider. An unannounced visit had taken place in November 2021 and again in April 2022. Where identified, there was evidence that some, but not all, actions to address areas requiring improvement were being progressed or had been completed. Some of the areas identified in these audits that were also identified in the course of this inspection included that staff appraisals were not taking place in line with the provider's policy, the provider's complaints policy was not implemented regarding longstanding, open complaints, not all residents had a current personal development plan, and the oversight and provision of staff training required improvement.

It was noted that a number of other audits and checks were being completed on a regular basis in the centre. Areas monitored included medication management, fire safety, maintenance of the premises, and practices associated with infection prevention and control (IPC).

When reviewing the complaints log, it was found that two long-standing complaints remained open. They had not been escalated to the provider's complaints officer, in line with their policy. From discussion with staff and management, it appeared that these were no longer current concerns and as such could possibly be closed. There was evidence that more recent complaints were either addressed to the satisfaction of the complainant or were in the process of being followed up by the provider.

The inspector requested to see the training matrix for the designated centre. The person in charge was in the process of developing this matrix and advised that they were unable to access all of the required records for the staff team. A review of

what was available indicated that a number of staff required training in a number of the areas identified as mandatory in the regulations. These included fire safety, training in the management of behaviour that is challenging including de-escalation and intervention techniques, and infection prevention and control. A number of residents living in the centre were prescribed emergency medication to treat a diagnosed medical condition. It was identified that there was not always a staff member working in the centre who had received recent training in the administration of this medication. As a result of this finding, the provider was issued with an urgent action to outline how they would ensure that staff had the required training to ensure residents who may need to be administered medications on an emergency basis were safe living in the centre.

Planned and actual staff rotas were available in the centre. From a review, the inspector assessed the staffing was routinely provided in the centre in line with the staffing levels outlined in the statement of purpose. Staff meetings were taking place quarterly in the centre. The next meeting was planned for the month following this inspection. Staff who spoke with the inspector were very knowledgeable about the residents. Staff spoke positively about working in the centre and the support that members of the team gave to each other. Management were highly complimentary about the staff team praising their commitment and demonstrated flexibility during the recent challenging periods in the centre.

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. Initially the most recent version of this document was not available in the centre. This was provided during the inspection. This document met the majority of the requirements of the regulations. Some revision was required to ensure that the information included was accurate and reflective of the services currently provided in the designated centre and that additional information regarding the emergency procedures in the centre was included.

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

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

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. Residents received continuity of care and support from a

consistent staff team. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

From the records reviewed none of the staff team had recently attended training in fire safety or managing behaviour that is challenging. Records regarding training in infection prevention and control and hand hygiene were not available for all of the staff team. An urgent action was issued to ensure that at least one staff working in the centre at any given time had recent training in the administration of emergency medication prescribed to a number of residents.

Judgment: Not compliant

Regulation 23: Governance and management

It was identified that the implementation of the COVID-19 isolation plan in this centre resulted in a repeated breach of Section 46 of the Health Act. There was a clearly defined management structure in place. However, there had been a recent reduction in the number of management personnel who worked in the centre. It was identified that increased management oversight was required regarding staff training, residents' personal plans, complaints and the revision of safeguarding measures in the centre. An annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed. As has been identified in other centres operated by this provider, the annual review did not involve consultation with the residents, as is required by the regulations. There was evidence that where issues had been identified, some actions were completed to address these matters. However other issues identified remained at the time of this inspection. Staff supervision and appraisals were not taking place in line with the provider's own policy.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that all of information included was accurate and reflective of the services currently provided in the designated centre. Additional information regarding the emergency procedures in the centre

was to be included. It was also required that the most up-to-date version of this document was available to residents and their representatives in the centre.

Judgment: Substantially compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The provider gave written notice of the arrangements in place for the management of the centre during the absence of the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

Not all complaints in the centre had been closed or escalated to the complaints officer in line with the provider's own policy. These complaints did not pose a medium or high risk to residents.

Judgment: Substantially compliant

Quality and safety

Residents appeared happy living in this centre and received person-centred supports that enabled them to be involved in activities that they enjoyed. Systems had been put in place to protect residents from abuse. Some improvement was required in personal development planning, the timely review of residents' plans, and the arrangements should a resident present with symptoms of COVID-19 or any other transmissible infection.

An activities coordinator had previously been employed in the centre. This was now the responsibility of the staff team. From speaking with staff and reviewing documentation, it was identified that residents were involved in a range of activities. It was acknowledged that residents were not yet participating in community-based activities to the same level as they had prior to the COVID-19 pandemic. The recent outbreaks in the centre had also limited residents' movement. It was a current goal of the staff team to support residents to spend more time in their local community. In recent weeks residents had been to a concert, the cinema, a pet farm, neighbouring towns, the local supermarket and the hairdresser. Other community-based activities included walks in local areas, swimming, going out for coffee or a meal, attending mass, and visiting churches and other spiritual places. Two

residents had participated in a social farming programme and had really enjoyed it. Residents also spent time visiting family members. A number of recreational facilities and activities were available to residents when in the centre. These included a number of televisions, DVDs, radios and music players, knitting, bowling, arts & crafts, puzzles and boxes of items that staff had prepared for some residents based on their interests. A music session was also held regularly in the centre and was very popular with the residents.

The inspector reviewed a sample of the residents' assessments and personal plans. 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 mealtime support plans. A personal communication dictionary had been developed for residents who were not verbal communicators to document how they used body language to communicate with others. The inspector was informed that a multidisciplinary review of each plan had been completed in January 2022, however there was no documentation regarding these reviews available in residents' files. It is a requirement of the regulations that any recommendations arising out of a multidisciplinary review, including those responsible for following up on those recommendations, are recorded.

Residents' healthcare needs were well met in the centre. Residents had an annual healthcare assessment. Where a healthcare need had been identified a corresponding healthcare plan was in place. There was evidence of input from, and regular appointments with, medical practitioners including specialist consultants as required. There was also evidence of input from allied health professionals such as nutritionists. A number of residents had documented recommendations regarding feeding, eating, drinking and swallowing. These had not been reviewed in the previous 12 months, as is required in the regulations. Staff advised that where any concerns or changes had been noted, reviews were arranged. It was also noted that dental appointments had not been arranged with the frequency outlined in residents' oral healthcare plans. 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. Although they had been regularly reviewed, it was not possible to determine what, if any, progress had been made in achieving these goals. Rather than detailing how or when a resident had been supported to achieve their ambition, each review read by the inspector stated that the resident 'continued to meet their goals'. It was noted that a number of goals had been repeated from the previous year. One resident did not have a current a personal development plan. It was assessed that the development, implementation and review of personal development plans required improvement.

Residents who required one, had a behaviour support plan in place. The inspector

was told that staff had been involved in the development and review of these plans. On review by the inspector, it was noted that in some the focus was on how to respond to incidents, rather than how to prevent them occurring. From speaking with members of the staff team, it was clear that they took a proactive approach and had a good understanding of the supports each resident required. Notifications had been submitted to HIQA regarding the use of restrictive procedures in the centre. It was not clear to the inspector that all of these interventions met the definition of a restrictive procedure as outlined in the provider's own policy. The person in charge committed to following up on this.

The person in charge advised that one resident had gone through a very challenging few months while a medication review was underway. There had been a notable improvement in this resident's presentation in recent months and they now appeared happier and more at ease. This improvement resulted in a reduction of adverse incidents in the centre. The person in charge told the inspector that further medication changes were planned and it was hoped that these would be less challenging for the resident and their peers.

A number of residents in the centre had safeguarding plans in place. When reading these plans the inspector identified that they had not been reviewed to assess if they were effective in keeping residents safe or if any changes were required. These plans stated that all staff were trained in the management a challenging behaviour. As outlined in the previous section, this was not the case at the time of this inspection.

During the inspection, management advised of a potential admission to the designated centre. If it were to go ahead, this would require a resident who currently had their own bedroom to share. At the time of this inspection, two residents were the sole occupants of twin bedrooms. Staff expressed concerns regarding either of these residents sharing with someone else. The inspector's review of the complaints log identified that one of these residents had previously shared their bedroom and this had changed following a complaint by their roommate. Given these concerns and the number of adverse incidents reported in the centre, the inspector requested additional assurances from the provider regarding this proposed move at the feedback of this inspection.

As outlined in the first section of this report, the centre was decorated in a homely manner. It was clean, bright and personalised to the residents living there. It was clear that the staff team put effort into making it as comfortable as possible for the residents. Staff told the inspector that the sound of the doors closing was difficult for some residents. As a result a number of the self-closing mechanisms had been changed to ones that made less noise. Further replacements were planned. Some areas requiring maintenance were identified. These included loose mobility aids in one of the bathrooms and some areas in the large living room that required re-plastering and re-painting.

There was evidence of good infection prevention and control (IPC) practices in the centre. One staff member showed the inspector around the centre and spoke about staff practices regarding the use of personal protective equipment (PPE), monitoring

of symptoms and other IPC practices. Cleaning schedules were in place and included mobility aids and other equipment. Overall the centre was observed to be clean. Some exceptions to this included a room where second freezer was stored and a light fitting in the smaller living room. It was also noted that there was mould in the corner of the ceiling in one bathroom. A number of damaged surfaces were also observed in the centre. These included couches and chairs in the larger sitting room, the kitchen table cover and some storage units, trolleys used to move towels & personal items, and some bathroom storage units and fittings. Due to the damage it would not be possible to effectively clean these surfaces. Information regarding IPC training for all members of the staff team was not available on the training matrix. As a result, it was not possible to determine if all staff had received this training.

As outlined in the previous section of this report there had been two COVID-19 outbreaks in the centre in the last nine months. Staff and management had worked together to support residents during these challenging times. The inspector was informed that during the most recent outbreak, one resident who ordinarily shared a bedroom had slept in the living room so as to isolate from their peer. This resident coped well with this change, with staff reporting that they slept well and appeared to enjoy it. As outlined previously, the documented COVID-19 isolation plan referred to residents who needed to isolate staying in an unregistered building. This required review to ensure that the implementation of the isolation plan was consistent with the centre operating in line with the Health Act. The isolation plan also needed to reflect learning from outbreaks and to consider the possibility of more than one resident who shared a bedroom needing to isolate from their peers. The COVID-19 folder available in the centre required review to ensure that it contained the most recent guidance and information issued by public health.

Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences, interests and wishes. Staff were supporting residents to engage with more community-based activities, as was the norm for them prior to the COVID-19 pandemic.

Judgment: Compliant

Regulation 17: Premises

The designated centre was clean and decorated in homely manner. The design and layout met the needs of the residents. The centre was generally in a good state of repair however maintenance and cleaning were required in some areas.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare-associated infections including COVID-19. The COVID-19 contingency and isolation plan required review to ensure that it was consistent with the Health Act and reflected the possibility that more than one resident who shared a bedroom may be required to isolate from their peers. The centre was observed to be clean. However a number of damaged surfaces were observed in the centre. It would not be possible to effectively clean these.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs of each resident had been completed. Each resident had a comprehensive personal plan. The inspector was informed that a multidisciplinary review of each plan had taken place in January 2022 however records of this review and any recommendations made were not available in residents' personal plans. Improvements were required in the development and review of residents' personal development goals. Not all residents had a current personal development plan. It was identified that many residents' feeding, eating, drinking and swallowing plans had not been reviewed in the last 12 months, as is required by the regulations. Staff advised if any concerns arose in that area, a review was arranged.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Dental appointments had not been arranged with the frequency outlined in residents' oral healthcare plans.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Staff had sufficient knowledge to support residents whose behaviour at times was challenging. It was not always documented in plans how to prevent, or address the cause of, a resident's behaviour. The provider was required to determine if some of the practices used in the centre were restrictive procedures, as notified to HIQA, in accordance with their own policy and evidence-based practice. The lack of recent training in the management of behaviour that is challenging is addressed in Regulation 16. .

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding plans had not been reviewed in line with the documented timelines to assess if they were effective in keeping residents safe. All staff had received appropriate training in relation to safeguarding residents and the prevention, detection, and response to abuse.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for North County Cork 5 OSV-0003298

Inspection ID: MON-0033387

Date of inspection: 30/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The training matrix will be discussed at the PIC/PPIM's 1:1 meeting to ensure that the provider is meeting its obligations in the provision of mandatory and other training. To take place quarterly. To be completed 31.10.22 • The PIC will schedule staff training. Training matrix update completed on 04.10.22. • All staff fire training will be completed fire training by 6.10.22. • All staff will have completed infection control refresher training by 15.11.22 • All staff will have hand hygiene completed by 6.10.22 • Three staff are outstanding to complete training on the administration of emergency medication. To be completed by 30.11.22. At all times there is a staff on duty who is trained in the administration of emergency medication since 30.08.22 • Sixteen staff to have completed MAPA training by 28.2.23 • Six staff to have completed positive behavior support training by 31.12.22	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The registered provider shall 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. If the manager is absent the senior staff on	

duty will take on the day to day management onsite. The PPIM will also be available to support the designated centre in PICS absence. Reflected in the statement of purpose. Completed on 01.09.22
• All care plans to be audited. To be completed by 30.10.22
• Action plans will be developed on the outcome of audits by the PIC. To be completed by 15.11.22
• All actions from care plan audit will be completed by 15.12.22
• All staff performance management has been scheduled to be completed by 15.11.22
• Annual reviews will reflect consultation with residents. To be completed at the next annual review 31.01.2023.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The statement of purpose was reviewed and updated to reflect services provided and includes reference to emergency accommodation should the need arise Completed on 01.09.22
• A updated copy of the statement of purpose is available to residents and their representatives.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• One out standing complaint has been escalated to the Safety Officer / Complaints Officer and also to the Occupational Therapy manager. To be completed by 31/01/23
• All outstanding complaints have been reviewed by PIC and signed off. Completed 04.10.22

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Identified premises repairs submitted on maintenance PEMAC system

Damaged surfaces to be repaired: To be completed by 30.11.22 Kitchen table coverings discarded 29.09.22 Light fitting: To be cleaned by maintenance 15.10.22 Sitting room: Couch to be replaced. To be completed by 15.02.23 Sitting room: To be reviewed by contractor and repainted. To be completed by 31.12.22 Mobility aids in bathroom loose. To be tightened by contractor. To be completed by 15.11.22 Trolleys to be replaced. To be completed by 15.11.22

Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • The COVID-19 contingency plan was reviewed and update by the PIC. Completed on 01.09.22 • Damaged surfaces have been submitted to be repaired. To be completed by 30.11.22	
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: • Records of Multi-disciplinary Team review will be placed in each residents' care plan. To be completed by 30.11.22 • Each residents SLT recommendations will be discussed with the SLT manager and updated accordingly if SLT manager deems necessary. To be completed by 31.01.23 • All residents' PCPs plans will be reviewed by their keyworker in conjunction with resident and their representative if they wish. To be completed by 31.12.22	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • Residents' oral healthcare will be reviewed and appointments with their dentist will be	

scheduled. Healthcare plans will be updated accordingly. To be completed by 31.12.22

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• Staff had sufficient knowledge to support residents whose behaviour at times was challenging. It was not always documented in plans how to prevent, or address the cause of, a resident's behaviour. The provider was required to determine if some of the practices used in the centre were restrictive procedures, as notified to HIQA, in accordance with their own policy and evidence-based practice. The lack of recent training in the management of behaviour that is challenging is addressed in Regulation 16.
• Residents support plans will be reviewed and documentation updated to address how to prevent, or address cause of a residents' behaviour . To be completed by 31.12.22
• Restrictive practices within the designated will be reviewed to reflect alleviated restrictive practices where necessary. To be completed by 30.10.22

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC has arranged to meet with the Designated Officer to review current safeguarding within the designated centre. To be completed by 30.11.22
• All open safeguarding within the centre will be reviewed by the PIC and documentation closed off as appropriate. To be completed by 30.11.22

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Red	28/02/2023
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 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	Not Compliant	Orange	01/09/2022

	safe, appropriate to residents' needs, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	31/01/2023
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	15/11/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of	Substantially Compliant	Yellow	30/11/2022

	healthcare associated infections published by the Authority.			
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	01/09/2022
Regulation 03(3)	The registered provider shall make a copy of the statement of purpose available to residents and their representatives.	Substantially Compliant	Yellow	01/09/2022
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.	Substantially Compliant	Yellow	04/10/2022
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: all complaints are appropriately responded to.	Substantially Compliant	Yellow	31/01/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional,	Substantially Compliant	Yellow	30/11/2022

	of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/01/2023
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 the plan.	Substantially Compliant	Yellow	31/12/2022
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall	Substantially Compliant	Yellow	30/11/2022

	be recorded and shall include any proposed changes to the personal plan.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	31/01/2023
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/12/2022
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	30/10/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Substantially Compliant	Yellow	31/12/2022

	this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/11/2022