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:	East County Cork 1
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	12 February 2024 and 13 February 2024
Centre ID:	OSV-0003305
Fieldwork ID:	MON-0042495

About the designated centre

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

The designated centre provides full-time and shared residential care and support for up to 18 adult males and females with intellectual disability and / or autism. The centre is located within a large town. The centre is a single storey building, with residents having access to communal facilities such as a large sitting room, dining room, relaxation area and kitchen. There are 10 single occupancy and four shared (double occupancy) bedrooms in the centre. Some bedrooms have access to en-suite bathroom facilities. The centre further provides residents with bathroom and laundry facilities, visitors / quiet room and garden areas that were well maintained. In addition, the centre has a staff office and staff toilets. Residents are supported by both nursing and care staff at the centre. At night-time, residents are supported by two waking staff on duty. A day service is adjacent to the designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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
Monday 12 February 2024	14:00hrs to 19:30hrs	Laura O'Sullivan	Lead
Tuesday 13 February 2024	08:00hrs to 13:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

This was an unannounced risk inspection completed in the designated centre of East County Cork 1. In recent months there was an increase in notifications being submitted to HIQA from the centre pertaining to resident interactions and the potential negative impact of these. The provider had submitted, upon request by the Chief Inspector, assurances of actions and measures to be implemented by the provider to address this. The inspection was completed over two days to allow the inspector the opportunity to meet and interact with residents. Also, the inspector observed interactions in the centre between all present.

On arrival, the inspector was informed that the person in charge was not present but the senior staff facilitated the inspection. The person participating in management chose to attend the centre also. The centre consists of a residential building with an adjoining day service. Several residents on the inspector's arrival were attending the day service. Staff were present should a resident decide not to attend the day service and to remain in the house. Two residents were relaxing in the living room and greeted the inspector. One welcomed the inspector and told them they would have a chat with them later.

Residents called to the office throughout the first day to say "hello" to the inspector and to tell them their plans for the evening. It was noted that there was an increased number of staff present on the evening of the inspection but with only one vehicle available only a small number of residents could leave the centre at a given time. The minimum staffing requirements in line with the current statement of purpose as four staff but on the evening of the inspection there was eight staff present with no rationale for the increased numbers.

One resident had a support plan in place noting the requirement of 1:1 staff support. This was also noted in a number of safeguarding plans. It was observed by the inspector, however that this resident was being supported to attend a social outing with another resident with only one staff present. When this was questioned by the inspector a second staff was to attend. The activity did not proceed as planned as the resident became upset in the vehicle and returned to the centre for an alternative activity. As will be discussed later in the report further clarity was required in how this 1:1 support was to be afforded and when.

The inspector chatted with one resident in the corridor, they brought the inspector to their bedroom to show them around. When they were chatting about life in the centre the resident told the inspector that it was good most of the time but they don't like it when another resident is giving out or when they get angry. When asked did that happened a lot the resident nodded and said "it annoys them". They chose

not to interact with the inspector on this topic any more but did say they had complained to the staff before. They like to go to the pub with their family on a Tuesday and like to go to their day service.

Another resident was relaxing on the couch in the living room later in the evening. They asked the inspector if they wanted to see the new television in their room and were excited to show this. This resident shared a room with a fellow resident but told the inspector they enjoyed this as they were good friends. The inspector asked the resident if they liked living in the centre and they responded sometimes. They told the inspector they didn't like when a resident "gives out" to staff or their friends. The resident was getting ready to go to the local pub with staff for a drink, but they said the other resident they spoke of was going also. They told the inspector that is unfair that the resident was always getting to go out places, more then other people. The resident was visibly upset when discussing this with the inspector. A staff member provided support when the inspector said goodbye and thanked the resident. This resident came to say "hello" to the inspector on the second morning and said they had a good night in the pub the night before.

Other residents chatted with the inspector through the course of the inspection, with some choosing not to engage which was respected. It was observed in the evening of the first day of inspection that staff interacted jovially and respectfully with residents. The inspector had the opportunity to speak with some staff. It was expressed that it can be difficult to support all residents given some individual behaviours of concern that they felt were impacting other residents. It was observed that when staff were interacting with residents, another resident would continuously attempt to gain their attention despite having staff support at this time. Staff felt if they did not engage that the situation would escalate. This was observed to cause distress and annoyance to some residents. One resident told them to be quiet and leave them all alone. Staff spoke of raising their concerns to the management through the team for example, as much of their negative interactions occurred outside of 9 to 5 governance times. No change had been noted following this concern being raised.

On the morning of the second day of the inspection, the inspector sat and chatted with some residents over a cup of coffee. When chatting with residents about their day, one resident present continuously attempted to gain the inspector's attention. One resident put their eyes up to heaven and told the inspector not to bother that this always happens and they would speak to them later instead when they were alone. Another resident was chatting with the inspector and staff about their upcoming holiday to Killarney and was listening to favourite 80's music on their phone. It was observed that this resident was becoming frustrated when the conversation was being interrupted. Staff were observed to attempt to engage with all residents and to ensure all the time was to be afforded to them.

Staff were observed supporting all residents. When one resident was observed to

become upset when leaving to go to an appointment staff provided the required reassurance and the resident left the centre laughing and smiling. Residents were observed to be very comfortable in the company of staff and laughed and joked with them throughout the day. Residents came to and from the office freely with some being supported to self-medicate. Staff chatted with residents about their day, family and goals. Staff however, were not aware of all measures which were to be implemented to support a resident's behaviour of a concern including an activity routine and staff supervision. In one meeting it was noted to reduce the impact of one resident's behaviours was to move residents to the adjoining day service, with a note that this was not in compliance with regulations. It was confirmed by staff and members of the governance team that this had occurred.

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 the quality and safety of the service being delivered

Capacity and capability

As stated previously this was an unannounced risk-based inspection completed in the designated centre of East County Cork 1. The provider had submitted, upon request by the Chief Inspector, assurances of actions and measures to be implemented to address to reduce the impact of a resident's behaviours of concern on their peers. Evidence of adherence to this plan was not evident on the day of the inspection. This included such areas as staff training, access to advocacy services for residents and adherence to the complaints procedure.

The provider had appointed a suitably qualified and experienced person in charge of the centre. They were supported in their role by a senior staff nurse and reported directly to the person participating in management. Throughout the inspection, there was no evidence provided of governance oversight to ensure the service being provided was safe and effective for those availing of the service. For this reason, the provider was issued with an urgent action on the day of the inspection for Regulation 23: Governance and management, Regulation 9: Residents' rights and Regulation 8: Protection.

The provider had ensured the completion of an annual review of service provision in the designated centre. However, this was completed without consultation with residents. It also did not highlight areas of non-compliance known in the centre including protection, governance and staffing. Therefore, no actions had been taken to ensure this was addressed in a timely manner. Staff meetings were held every month to discuss the operations of the centre. However, where it was noted a concern was being raised by staff no actions were implemented to address this. This included the need for increased governance hours to support staff to manage a known situation. This was not highlighted in the annual review. It was discussed in

the annual review that safeguarding was discussed at resident forums, there was no evidence of this. It also stated that residents were supported to attend an advocacy meeting on the first Wednesday of the month in the centre. This was not occurring.

The most recent six-monthly unannounced visit to the centre was completed by the delegated person in October 2023. In this, several actions had been highlighted including the right for residents to attend their multi-disciplinary meetings. While these had recently been completed the need for actions had been pushed out twelve months. There was no plan to support the residents to achieve the required skills and awareness to prepare for the next annual multi-disciplinary meetings or those which could occur in the meantime. It was also noted that the person in charge was to meet with the regional manager to discuss living arrangements for residents. This had not occurred. Actions from the previous visit remained open with no evidence if these had been completed.

Regulation 15: Staffing

The registered provider had appointed the assessed required skill mix of staff to the centre. It was noted that should the staff nurse be absent from the centre, medical appointments were cancelled including chiropody and GP.
While an actual roster was present this did not accurately reflect the staff members present. For example, on the day of the inspection, there were eight staff members in the centre not all present on the roster. The roster reviewed did not include all staff. When one resident had the allocation of 1:1 staff it was not noted on the roster who was to provide this support.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector was unable to ensure the staff team were afforded and facilitated to attend training in the centre as the training records on site were not reflective of the current training needs. The provider had stated that staff were to receive site-specific training in such areas as protection and behaviours of concern. It was not evidenced that this had been completed for all staff.
The inspector had requested for all training records to be submitted following the inspection. This was not received at the time of writing the report.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that management systems were in place within the centre to ensure the service was safe, appropriate to the assessed needs, consistent and effectively monitored. Where an ongoing concern had been identified there was no evidence provided on the day of the inspection to assure that this had been escalated to the provider through the providers risk escalation process.

While an annual review of service provision was completed for 2023, this did not highlight the areas of concern within the centre with no actions were identified to ensure these were addressed in a timely manner. Upon review of staff meeting records it was noted that should staff raise concerns with respect to the quality and safety of care support provided to residents no actions had been taken.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had ensured the development of a complaints procedure including an organisational policy and accessible information for residents. It was noted however on the day of the inspection that improvements were required to ensure adherence to this:

- Where one resident had raised a complaint there was no record maintained of this.
- Where complaints had been submitted for or by residents it was not clear how the satisfaction of the complainant had been achieved.
- Actions taken to address the complaint were not relevant to the individual making the complaint but who the complaint related to.
- When a resident make a second complaint about a similar incident this was not addressed as new complaint.
- The complaint records highlighted a complaints officer who was no longer in the role.

Judgment: Not compliant

Quality and safety

East County Cork 1 was a designated centre located on the outskirts of a large town. The centre can provide full time residential supports to 18 adults. On the day of the inspection an urgent action was issued to the provider to ensure effective measures were implemented to promote residents rights and to ensure all residents in the centre were protected from all forms of abuse.

Over recent months there had been a noted increase in behaviours of concern being displayed by one resident due to a change in their personal circumstances. This was having a negative impact on peers and was observed by the inspector on the days of the inspection. This resident had been in receipt of multi- disciplinary supports including psychology and behaviour support. However, upon review of the individual's personal plan and discussion with staff, not all staff were aware of the behaviour support guidance in place. It had been reported that the resident was supported through an activity planner, staff were not aware of this. This information was found in another folder on the second day of the inspection. Where the resident had 1:1 support there was no guidance in how this was to be implemented or by who.

While this resident had been afforded the support of the multi-disciplinary team to support these behaviours, others residents were not facilitated with this level of support to ensure they received full support at the time of negative impact. One resident had self-referred for psychology support as they were finding the situation in the centre difficult to navigate. At the time of the inspection it was noted that there was a six month waiting time for this referral with no documented rationale or evidence of follow up.

It was reported to HIQA through statutory notifications and a requested provider assurance report that all residents in the centre had access to advocacy services. It was noted on the inspection an internal advocate had attended the centre to meet with staff and residents. While the meeting notes were present for the staff meeting, there were no record or evidence of the resident meeting being completed. The records were requested to be forwarded to the inspector after the inspection but had not been received of the time of the report being written. It was noted in staff meetings that a monthly advocacy meeting was to be completed in the centre by a delegated staff. These were not completed.

While residents meetings were being completed, these focused on topics decided upon by the staff members and not residents. Notes maintained of these were not in an accessible format for residents to review. Upon review of meetings notes it was evidenced that the areas of safeguarding and keeping safe had not been discussed.

The registered provider had not ensured that each resident in the centre was assisted and supported to develop the knowledge, self-awareness and understanding to protect themselves from abuse. Practices in place did not ensure all residents within the centre were protected from abuse. Where identified safeguarding concerns were present, there was conflicting information with respect to measures to be implemented to reduce this risk and to maintain the safety and well-being of all individuals. In some personal plans there were up to five safeguarding plans with it being difficult to ascertain the current plan. As discussed previously actions to be taken in the plan were relevant to the person alleged to be causing concern rather than the alleged victim of the abuse.

The registered provider had not ensured effective measures were in place to identify and assess risk within the centre. Where a particular concern had resulted in a known negative impact on others this remained a low risk and had not been

escalated through the required platform. A number of risk ratings reviewed did not reflect the actual likelihood and impact of the risk within the centre including pregnant employees, safeguarding and behaviours of concern. Where an escalated risk had not been accepted by the senior management team this remained on the risk register and rated high with no additional control measures documented to reduce the risk noted. It is also noted that on the day of the inspection staff and management present were unaware of the location of the provider risk policy.

Regulation 26: Risk management procedures

The registered provider had not ensured effective measures were in place for the ongoing identification, assessment and review of risk within the centre. Risk assessments reviewed on the day of the inspection did not accurately reflect the impact and likelihood of an identified risk. This included areas such as behaviours of concern, safeguarding and protection.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Staff within the centre were not supported to have up to date knowledge and skills to respond to behaviours that are challenging and to support residents to manage their behaviours. While a behaviour plan may be in place staff were not aware of this are procedures to follow. Staff also noted that the majority of incidents occurred in the evening or at the weekend when no member of the governance team were present. However, it was noted all meetings to review the behaviours of concern were completed by the governance team with some staff noting no communication pertaining to these reviews.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured that each resident in the centre was assisted and supported to develop the knowledge, self-awareness and understanding to protect themselves from abuse. Practices in place did not ensure all residents within the centre were protected from abuse. Where identified safeguarding concerns were present, there was conflicting information with respect to measures to be implemented to reduce this risk and to maintain the safety and well-being of all individuals. For example, it was unclear when 1:1 support was

afforded to a resident, how this was implemented and who the assigned staff was.

Where it had been highlighted that an interim safeguarding plan was not effective to reduce the risk and maintain the safety of residents, no actions had been taken to review this plan. Safeguarding plans reviewed set out actions to support the person alleged to have caused the concern not the alleged victim. This required review.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had not ensured the designated centre was operated in manner which supported and promoted the rights of all residents currently residing in the centre. The registered provider had not ensured that residents' dignity was respected in relation to their living environment and personal relationships. For example, residents reported having to leave a communal area of the house to accommodate others against their will and preference. Residents told the inspector of feeling unsafe at times in the living room and moving to their bedroom to feel safe.

Where residents had raised concerns pertaining to the designated centre, evidence of actions to be taken to address these concerns were not implemented to ensure residents were consulted in the running of the centre. Practices within the centre did not afford residents the opportunity to participate in and consent to decisions about his or her life. For example, residents had not been consulted in-:

- The most recent annual review of service provision in the centre
- The six monthly unannounced visits to the centre.
- Development and review of interim safeguarding plans.
- Individual multi-disciplinary meetings.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for East County Cork 1 OSV-0003305

Inspection ID: MON-0042495

Date of inspection: 12/02/2024 and 13/02/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • All appointments will be scheduled and the PIC or senior staff will identify a staff member to support the resident to attend appointments. • The PIC will review the roster to ensure each staff member in the designated centre is identified and a senior staff is identified in the absence of the PIC to ensure effective governance and oversight. • Supervision of a resident by staff will be identified daily on the roster. • A business case has been escalated to the HSE by the Chief Operations Officer for additional staff funding to support 1:1	
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 for the centre has been reviewed and updated to reflect completed training and scheduled training. • Safety Intervention training has been completed by eleven staff. A further eight staff have scheduled to complete training on the following dates April 22nd -23rd x two staff, May 20th -21st x four staff, June 17th-18th x one staff July 8th-9th x one staff.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

23 (1)c

• The skill mix within the designated centre will be reviewed by the Chief Operations Officer in consultation with the PIC and PPIM to ensure that the service provided is safe and appropriate to resident's needs. To be completed by 31.05.2024

• Training to support the staff team will be provided on incidents / NIMS, complaints procedure, and completion of safeguarding forms. Dates for completion have been outlined in actions above. Additional training and support will be provided by Positive Behaviour Support Team , Psychology Department , Social Work Department and Advocacy officer.

• A structured agenda will be agreed upon by the PPIM and PIC for team meetings with identified responsibility and outcomes. Quarterly team meetings will be scheduled for 2024 by 28.02.24.

• Risks within the Designated Centre will be reviewed and the process identified in the organisation policy will be followed to ensure effective care and support. Any identified high risks will be escalated to the PPIM which, if accepted will follow the process of escalation to the Chief Operations Officer and, executive followed by the board in appropriate by 28.02.24.

• The staff team will be informed of the process to ensure they have the opportunity to exercise concerns on behalf of the residents and the PIC will be reviewing complaints and actions arising from them on a monthly basis.

Completion date: 28.02.24

23(1) d

The annual review process for the designated centre will be reviewed to ensure the auditor is effectively capturing the quality and safety of care and support, clearly identifying actions through areas of improvement. The annual review will also incorporate evidence from 6 monthly audits, residents views through residential forums, resident and representative surveys and advocacy meetings. The annual review will incorporate a review of the NIMS, Safeguarding plans and escalated risks to ensure that any areas of concern are identified and any actions required are completed. This will be carried out as part of the next annual review December 2024.

Completion date: 30.12.24

23(2)b

The 6 monthly unannounced audit will be made available onsite for residents, representatives and Chief Inspector on request. Actions identified will be actioned, delegated to staff team and tracked accordingly on an electronic system with a hard copy available if required.

Completion date: 23.02.24

The annual review for 2024 will reflect areas of concern within the centre with any identified actions to ensure they are addressed in a timely manner. Completion date

31.12.24 Concerns raised by any staff member with regard to the quality and safety of care will be addressed locally through the risk management process or escalated as per risk escalation process to the executive Team. This process will addreessed at a staff meeting Completion date 12.04.24

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • A retrospective complaint was completed for a resident. • The staff team will complete training on the complaints procedure and how to action so they can close the complaint or escalate to the PIC or the complaints officer if locally the complaint can not be closed. • The complaints procedure documentation has been reviewed and updated to reflect an appeals procedure, for making a complaint. The correct information is available for residents, their representative and staff.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The risk management policy will be referred too, to ensure risks are identified, assessed and reviewed within the designated centre. All staff will be made aware of this policy to ensure that staff have the knowledge and system to raise concerns about the quality and safety of the care and support provided to residents. • Individual risks will be reviewed to accurately reflect the impact and likehood of an individual risk. All individual risk assessments will be reviewed specifically concentrating on behaviours of concerns, safeguarding and protection. The risk register for the designated centre will also be reviewed.	
Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • The Positive Behaviour Support Plan for one resident has been reviewed by PBS and psychology with input from the staff team. All staff have read and signed understanding of the PBS plan. • The staff team have been assigned roles and responsibilities with regards updating documentation and the roster now identifies supervision support at necessary times. • The Multidisciplinary Team and management have met with the staff team to discuss the PBS plan and ensure there is a combined understanding and approach to the PBS plan. This will be reviewed by PBS on an ongoing basis. • A staff meeting was held on 15.03.2024. One residents Positive Behaviour Support plan and recent case conference updates were discussed with the staff team. The plan will be reviewed by Positive Behaviour Support to ensure its effectiveness and changes of strategies will be identified as the plan develops.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Regulation 8: Protection: 08(1) • As an identified action from a case conference held in relation to all residents of the designated centre on 15.02.24, representatives from psychology and social work will visit the residence to review the current plan that is in place for the PACC. They will meet with residents to promote self-awareness and to offer additional supports to anyone affected by the Safeguarding concerns. They will support the staff team to ensure they have the knowledge and skills required to support vulnerable residents in maintaining their safety and protecting them from abuse. An initial visit is scheduled for 21.02.24. Completion date: 30.03.24 08(2) • The Positive Behaviour Support plan for a resident identified as a person allegedly causing concern (PACC) is currently being reviewed to establish more precise guidance and recommendations. This review will also incorporate psychology recommendations. The PBS plan will also advise the level of support required at different times during the day for this resident. The review has commenced incorporating input from the Positive Behaviour Support Team, Psychology and social work. These identified MDT team members will be onsite in the Designated Centre on 21.02.24. Each team member will be met by the MDT team to review the updates or changes to the PBS plan and also be given guidance to complete any documentation associated with the PBS plan. • All open safeguarding plans in the designated centre will be reviewed by the PIC to ensure that all the actions are completed. One of these actions will be to ensure that the welfare of the person affected is monitored on an ongoing basis and appropriate	

supports are offered where necessary. The plans will then be regularly reviewed as part of the Safety Committee meetings to ensure correct information is available and that there is consistency across documentation and approach by staff in managing the safety of the residents. For plans that are deemed unsuitable, the measures identified in the plan will be updated to ensure effectiveness. Positive Behaviour Support will be invited to the next meeting as part of a team approach review.
• Recommendations from HSE social worker specialising in Safeguarding, will be implemented. This includes reviewing with the staff team the process of completing PSF1 for HSE safeguarding. This will be completed by a Social Worker from the organisation early in quarter 2.
• Safeguarding which has not been accepted by the HSE safeguarding team will be reviewed and resubmitted to the HSE safeguarding team by 26.02.2024.
• Training on completing incident forms / NIMS will be facilitated by the Health and Safety Team. A review of the number of incidents and near misses, escalated risks and safeguarding plans will be carried out as part of the annual review to determine any areas of concern within the centre and to highlight any actions required to address same.
Completion date: 26.04.24

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: 09(2)(a)
• The organization is currently reviewing the coordinated supports model (Individual MDT) and will ensure that the resident is consulted as part of the process and there is a mechanism for the resident to participate in and/or offer input to their own coordinated supports meetings if they so wish.
• Residents meet with their keyworkers regularly and are involved in their goal planning for their PCPs.
Completion date: 31.05.24

09(2)(b) & (c)
• The service currently operates a Resident forum on a weekly basis. The template agenda for the weekly Resident Forum will be reviewed by the Advocacy officer with input from residents and the staff team, to ensure that it offers residents the opportunity to express choice and control over the decisions that affect them within the designated centre. Any changes identified will be implemented as soon as possible. The resident's forums will ensure to provide information about any changes within the centre such as new staff members and offer residents the opportunity to express preferences and choices regarding the running of the centre (meals, activities etc.) This will ensure that any opportunities for improvement are captured and actioned. Each resident will have the right to add to the agenda for the meeting ahead of time and this agenda will be displayed on the residents notice board before the meeting in an accessible format.
• The Advocacy Officer will provide training for the staff team to ensure that they are confident and competent in facilitating both resident forums and Advocacy meetings. An

initial meeting will take place on 19.02.24 with the Advocacy Officer visiting the residents' home to meet them and the team and to develop a training plan based on the residents' needs and level of ability to ensure that the information will be provided in an accessible way. At this meeting the Advocacy Officer will also explain about independent advocacy services which will afford residents the opportunity to apply for 1:1 advocacy support if they so wish. The Advocacy Officer will provide accessible information for the Independent Advocacy Service which will be made available within the residence. A further meeting is scheduled for 26.02.2024.
• Advocacy meetings will be held on a monthly basis to educate the residents on their rights and responsibilities. Each month will have a themed information session and discussion (e.g. Voting, expressing emotions, UNCRPD).
Completion date: 15.03.24

09 (2)(e)
• Complaints from residents in relation to the designated centre are logged as per policy. The PIC will ensure that the complaints log will be reviewed on a monthly basis to ensure that all actions outlined have been completed. All staff will receive training in "Complaint Management" by a member of the Quality and Safety team in quarter 1 to ensure that staff are effective in supporting service users to express any concerns.
• The PIC will ensure that surveys are circulated to the residents and/or their representatives ahead of the annual review to ensure the feedback is reflected within the report.
• It will be a requirement of the 6 monthly unannounced reviews that the residents are consulted with regarding their experience within their home.
• Interim safeguarding plans will be reviewed by the local Safety committee on a 3-monthly basis. As part of this process the resident affected will be spoken with to ascertain their experience and/or satisfaction with the effectiveness of the plan to date.
• To ensure governance and oversight, the PIC will audit the minutes from the residents' forums to ensure that any actions outlined have been assigned a person responsible and are followed up on.
Completion date: 30.03.24
09(3)
• Every resident has a right to feel safe in their own home. A compatibility assessment for all the residents will be completed to ascertain any actions necessary to allow the residents to live together more harmoniously respecting all residents dignity.

Completion date: 30.09.2024

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	28/03/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	28/03/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional	Not Compliant	Orange	30/07/2024

	development programme.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/12/2024
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/12/2024
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	30/12/2024
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more	Not Compliant	Orange	30/12/2024

	frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	30/12/2024
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.	Not Compliant	Orange	31/07/2024
Regulation 34(1)(c)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible	Not Compliant	Orange	30/04/2024

	and age-appropriate format and includes an appeals procedure, and shall ensure the resident has access to advocacy services for the purposes of making a complaint.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	30/04/2024
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	30/04/2024
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	30/04/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to	Not Compliant	Orange	31/05/2024

	behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	31/05/2024
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	26/04/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	26/04/2024
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	30/09/2024

Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/09/2024
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Not Compliant	Orange	30/09/2024
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights.	Not Compliant	Orange	30/09/2024
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the	Not Compliant	Orange	30/09/2024

	organisation of the designated centre.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/09/2024