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 2
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	03 February 2021
Centre ID:	OSV-0003707
Fieldwork ID:	MON-0030998

About the designated centre

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

North County Cork 2 is comprised of three separate buildings, located within the environs of a large town on the outskirts of Cork City. Local amenities can be easily accessed such as shops, cinema and restaurants. The largest of the houses can accommodate 13 adults, male and female with an intellectual disability. It is a purpose built bungalow located in a cul-de-sac surrounded by a large garden area. The house is comprised of 13 individual bedrooms, one with an en-suite. In addition, there is a large kitchen-dining area, two sitting rooms, two bathrooms, two shower rooms, two water closets, a laundry room and a staff office. There is also a visitor area which is comprised of a small kitchen and sitting room which is located off the large reception area. There is a self-contained apartment adjoining this house which can accommodate three residents. It is comprised of three individual bedrooms, a kitchen, dining-sitting room, a shower room and laundry area. It is connected to the main house by a corridor. The remainder of the designated centre which is located in another residential area of the town is comprised of two semi-detached houses which have been joined internally and a two storey semi-detached house located next door. The larger house can provide support for up to eight adults from Monday to Friday and closes each weekend and during holiday periods. The residents are supported to attend day services and return to the designated centre in the evening. This house is comprised of one large sitting room, dining room and kitchen, two bathrooms and one shower room. There are nine bedrooms which includes a staff bedroom. The other house supports two adults and is comprised of three bedrooms, which includes a staff room. There is also a sitting room, dining room with separate kitchen and a bathroom. Each of the houses have parking facilities at the front and a garden area to the rear. Residents are supported by nursing and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 February 2021	10:30hrs to 16:45hrs	Elaine McKeown	Lead
Wednesday 3 February 2021	10:30hrs to 16:45hrs	Lisa Redmond	Support

What residents told us and what inspectors observed

The inspectors were able to meet with all of the 15 residents that were in the designated centre on the day of the inspection. The other 11 residents in receipt of services in the designated centre were being supported by family representatives since the pandemic restrictions began in March 2020 or since Christmas. To reduce movement between houses as a result of the COVID-19 pandemic and in line with public health guidance one inspector was located in the larger house and the other inspector remained in the co-joined semi-detached houses during the inspection. In advance of the inspection, the person in charge had requested the inspectors forward photo identification for the residents to know in advance who was going to be visiting their home. This request was facilitated.

On arrival to the larger house, the inspector was greeted by the person in charge and one resident and this resident welcomed the inspector. Three other residents were watching television in a cosy sitting room. They acknowledged the inspector and chatted easily about the weather and asked the inspector a few questions; including how long would the inspector be in the house for. The inspector met another two residents in the newly decorated kitchen. The kitchen area was bright, freshly painted with new units installed and had a more homely appearance since the last inspection. One resident was finishing their breakfast and showed the inspector a brightly coloured doll that they had with them. The other resident greeted the inspector with a big smile and looked warm and comfortable in a fashionable dressing gown which they showed the inspector with pride. This resident was also observed talking to staff about their new radio which they needed assistance with, staff immediately responded to the request and resolved the issue for the resident.

The inspector chatted with another group of residents in the larger sitting room who were observed during the day to engage in activities with staff which included, indoor bocci, an exercise programme and singing. Staff were observed to support one resident to go for a walk as they were a little anxious during the morning and staff explained the resident liked to walk long distances and were missing their family. Prior to the pandemic the resident would have spent the weekends with their family and they had been supported to stay with their family during the Christmas period which they enjoyed. This resident was observed to be much more relaxed in the afternoon and called the inspector by name at the end of the inspection. While residents were supported to participate in a number of different group activities during the inspection, other residents were observed to engage in some activities on their own which included knitting and writing postcards to send to family members and friends.

On the day of the inspection there were three staff on duty in the larger house, who were providing care and support for 14 residents. Additional staff who had been redeployed from the day services were part of this core group of staff due to two staff members unable to attend for work on the day of the inspection. The inspector

observed two residents being supported to have their breakfast during the mid-morning, while others watched daytime television. Other residents were seen to participate in small group activities, of between three to four residents during the morning and could be heard singing loudly as part of a larger group in the afternoon. Prior to the government restrictions, many of the residents attended day services during the week. While staff were aware some residents missed attending their day services, the inspector was informed that other residents have enjoyed a routine that has become less rushed in the mornings.

Residents who spoke to the inspector were very happy with their home but missed meeting their peers and going to their day services due to the pandemic restrictions. One resident told the inspector they were very happy to have received the COVID19 vaccination recently but enjoyed the spin to the vaccination centre and the takeaway on the way home a lot more. Residents spoke of how they were able to talk to family members regularly on the phone including making video calls. Some residents spoke of how much they enjoyed spending time with their families over the Christmas period and explained how they had occasional visits over the last few months. The inspectors were aware that some of the residents spoken to during the inspection had made complaints in recent months. Issues that were resolved included the provision of a DVD player for residents to watch films of their choice in the sitting room in June 2020 within a week of the compliant being made and the replacement of personal property that had been damaged within two days. One resident had made a complaint on behalf of a peer resident in January 2021. The inspector was informed that this was initially dealt with as a complaint and the designated officer was informed. However a notification regarding the incident was submitted retrospectively to the Health Information and Quality Authority, HIQA on 1 February 2021, 10 working days after the incident had occurred.

One resident showed the inspector their fairy garden. It was evident that this was something that the resident enjoyed, and they proudly showed the inspector the newest addition to the area. The resident also showed the inspector an altar that they had put in place to remember loved ones that had passed away. It was evident from speaking with the resident and the staff members that this was very important to the resident. In addition, this resident spoke about the programmes that they liked to watch on television. When the level 5 COVID-19 restrictions reduced, it was planned that satellite television would be installed for the resident. This would ensure that they could record programmes to watch later in the evening, and that they could then go for walks outside with staff support before it got dark. These plans were linked to the personal goals that the resident had identified at their person centred planning meeting. The resident also had a notebook that was important to them. The staff members wrote notes in the resident's notebook about their day, and the activities they had completed. The resident requested that staff members updated their notebook, to reflect their visit from the inspector.

Before the COVID-19 pandemic, one of the resident's had decided that they no longer wanted to attend their day service. This decision had been supported, and the resident was now provided with staffing supports during the day, in their home. During the inspection, the resident received an invitation to a coffee morning with friends from the day service. A tea bag had been included in the invitation to ensure

the resident had a hot drink to enjoy while they had a chat with their friends. Staff members told the inspector that due to the success of the coffee mornings that it was planned that these would become a regular activity. The resident told the inspector that they enjoyed the coffee morning, and the opportunity to catch up with their friends.

One resident told the inspector that a staff member could show them their bedroom. It was evident that the furniture was out-dated, however the resident told the inspector that new furniture had been ordered for their bedroom. The resident also showed the inspector an item that they had had since they were a child. It was evident that this item was very important to the resident, and it was kept in a safe location in their bedroom. The resident told the inspector that they liked their home, and that they were very happy living there.

The inspectors were informed that some residents had been supported to go home over the Christmas period and remained at home with their relatives at the time of the inspection; staff were in regular phone contact with them. At the time of the inspection no short term respite services were being offered in the designated centre. The person in charge outlined the change to the service provided to three residents living in the semi-detached houses as a result of the pandemic restrictions. These residents were being supported on alternate weeks from Monday to Friday, to ensure adherence to public health guidelines. One of the houses was not occupied at the time of the inspection. The inspector viewed this house and noted that a number of improvements had been made to the premises since the last inspection. A number of areas had been painted, flooring had been replaced, baths had been replaced with showers in line with residents' assessed needs and the house had been de-cluttered. The back garden had been upgraded to include flowers, plants, bird houses and garden furniture which could be enjoyed by residents. It was noted that the kitchen required upgrading as some wood was chipping away from the doors of the kitchen. One bathroom sink also required upgrading as there was some exposed piping visible.

Inspectors reviewed responses from families that were received by the person in charge in October 2020 regarding services in the designated centre, in advance of the annual review being completed by the provider. Responses were positive in nature referring to staff support and the care provided to their relatives. There were two observations made by some of the respondees that a sheltered area to support external visiting in the garden area might be beneficial while government restrictions were in place and additional lighting in the car park would help relatives when they were visiting the centre during hours of darkness. The inspectors were informed no family representatives had indicated that they wished to talk to the inspectors during the inspection by phone.

The inspectors observed staff to support residents in a professional and respectful manner during the inspection. Individual preferences regarding meal choices and preferred activities were considered during the day. The inspector in the larger house could hear sounds of laughter and regular conversations between peers and staff. The inspector in the other house observed accessible information about life in the centre in the sitting room of the centre. This included the designated centre's

statement of purpose, residents' guide and information on advocacy.

Capacity and capability

This risk based inspection was undertaken to provide assurance that actions identified during the last inspection in January 2020 had been completed prior to the renewal of the registration of this designated centre. The provider had addressed some of the actions from the previous inspection which included reducing the remit of the person in charge and updating the premises; delays were encountered in scheduling staff training due to the ongoing pandemic restrictions. However, not all notifications had been submitted as required, not all personal care plans had been subject to annual review and staffing levels to ensure the assessed needs of residents were begin met remained an escalated risk on the provider's risk register.

As an action from the previous inspection of the designated centre in January 2020, the provider submitted bi-monthly updates to HIQA, detailing progress been made within the designated centre to ensure compliance with the regulations. A finding of the January 2020 inspection was that the staffing levels required review to ensure that they met the changing needs of the residents. The person participating in management informed the inspector that a service review was completed in 2019. This service review was not available for the inspector to review at the time of the inspection. The inspector did review records of meetings held between the general manager and the allocations officer, with the most recent meeting taking place on 27 January, where staffing was discussed in relation to one of the houses in the designated centre and it was noted that the person in charge had escalated the risk of reduced staffing to senior management. At the time of the inspection one staff vacancy had been filled with another position due to be filled after the inspection. The inspector was informed a meeting had been scheduled to review the staffing levels in the other two houses in the designated centre after the inspection.

At the time of the inspection there were 19 staff employed in the designated centre, with one relief staff also available when required. Performance management reviews had been completed for all staff in June and December of 2020. It was noted that the training matrix provided to the inspector had not been updated to reflect trainings completed for all staff. The clinical nurse manager reviewed the training matrix on the day of the inspection. There was evidence of gaps in the delivering of mandatory training to staff members. For example, 10% of staff had not received updated fire safety training, however these were scheduled to be completed after the inspection. 10% of staff had not completed safeguarding training, while 25% of staff were to support the management of behaviours that challenge. It was noted that the provider was in the process of developing a memorandum of understanding with the external providers of this training. It was hoped that this agreement would ensure that staff could receive the theory element of this training, with the practical sessions being held when COVID-19 restrictions allowed.

The person in charge worked full time and had remit over this designated centre only. They were aware of their role and responsibilities including their oversight of staff supervision in the designated centre. In addition to the responsibilities of their roles, the person in charge and clinical nurse manager, CNM1 worked in the designated centre in recent months to support the residents and staff team when there were suspected cases of COVID19 in the designated centre.

The inspectors reviewed the complaints log in two of the houses in the designated centre. An easy to read version of the complaints process was accessible to residents in the designated centre, however it was noted that this did not include details on the appeals process. There was evidence that residents had been supported to make complaints verbally, which were documented and had been resolved to the satisfaction of the complainants in one of the houses. In another of the houses the inspector noted that four complaints that were reviewed involved residents reporting they had been upset or distressed as a result of the actions of others. The person in charge had notified the designated officer of all of the incidents but all actions taken were not always documented on the complaint log. There was one open complaint in the designated centre at the time of the inspection. This related to the damage of personal property of a resident. A notification relating to this incident had not been submitted to HIQA at the time of the inspection, it was subsequently submitted on 10 February. At the time of writing this report the provider was still investigating the incident.

The inspectors were informed the governance and risk meetings, as outlined in the compliance plan response to the last inspection which were to take place monthly between the person in charge and the person participating in management had only taken place once in February 2020 due to the pandemic restrictions. A new person participating in management was appointed by the provider in June 2020. The inspector was informed that this person had maintained regular phone contact with the person in charge since they took up the position. While the inspectors acknowledge the pandemic restrictions impacted on the ability to have regular meetings; the findings of this inspection have shown ongoing issues remain in the designated centre which were identified as requiring governance oversight in the compliance plan from the January 2020 inspection report.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted the application for the renewal of the registration of the designated centre as required by the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed and they held the necessary skills and qualification to carry out the role.

Judgment: Compliant

Regulation 15: Staffing

The person in charge had ensured there was a planned and actual rota in the designated centre. Staff shortages had occurred in recent months; the number, qualifications and skill mix of staff available to support the assessed needs was being reviewed by the provider at the time of this inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had a training matrix in place for the inspector to review however, there were gaps in the mandatory training for some staff at the time of the inspection.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had ensured that the designated centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had addressed some actions from the previous inspection, but had not ensured the monthly governance and risk oversight as outlined in the compliance plan submitted to HIQA following the January 2020 inspection had been completed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was subject to regular review. It reflected the services and facilities provided at the centre and contained all the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector had not been notified in writing of all adverse events as required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

Residents were aware of their right to make a complaint. However, measures were required for improvement in response to complaints.

Judgment: Substantially compliant

Quality and safety

There was evidence of some progress and improvements being made within the designated centre since the last inspection regarding the premises.
However additional improvements were required in a number of areas which included the review of some personal care plans, safeguarding and residents' rights.

Residents were supported to maintain contact with family and friends using phone and video calls during the pandemic restrictions. Family members were also supported to visit the designated centre while adhering to public health guidelines. At Christmas time, residents made Christmas cards and gave these to their family members and friends.

Inspectors reviewed four care plans during the inspection. There was documented evidence of review in three of the care plans, however, one plan had not been updated since January 2020. The person in charge was able to confirm some goals had been achieved or were in progress for the resident whose care plan did not have documented evidence of review since January 2020. The care plans that had documented evidence of review, included regular updating and re-adjusting of short term goals while adhering to public health guidelines. In response to the COVID-19 pandemic, some residents' person centred planning meetings had been held online. These were attended by the resident, staff members and a number of members of their close family, at the resident's request. The re-adjusted goals included assisting peers to learn how to use a tablet device and looking up recipes on the tablet device which they could make independently or with minimal support from staff. It was also noted that easy to read version of residents' care plans and personal goals were available in some of the personal files that were reviewed. Social stories were also available and these had been adapted to include the picture of the resident to promote their understanding.

Residents in the designated centre were supported by a multi-disciplinary team, MDT and had access to consultant services. The person in charge outlined the process recently followed to request the services of an external advocate to support one resident with decision making regarding their ongoing medical needs.

The provider had ensured that improvements had been made in the designated centre regarding the kitchen facilities in one house and the general maintenance of the houses. However, as previously mentioned in this report some maintenance issues were identified during the inspection which included exposed pipes in a bathroom and repairs to kitchen units.

Some residents were able to advocate for themselves and their peers in the designated centre. However, inspectors noted that all incidents that occurred in the designated centre were being reported by staff in a timely manner. For example, a resident reported an incident which they had witnessed to a staff member a day after it had occurred in January 2021. However, three days later another staff member reported that they had also overheard the incident but had not reported it at the time it occurred. At the time of the inspection, this matter was still being investigated by the provider. Another resident reported on 1 February damage had occurred to personal property in their bedroom; the volume button on the radio was no longer functioning. The resident reported to staff what had happened and when it had occurred. At the time staff reported that the incident had caused distress and upset to the resident. The inspector was informed that this incident was being investigated by the provider. Another incident that occurred on 6 December which caused distress to a resident was not reported by the resident until 10 December. The resident reported that they were not happy with the way they had been spoken to by a member of staff. Not all actions documented to resolve the matter had been completed which included refresher training in safeguarding by the staff member.

Emergency lighting, fire resistant doors and a fire alarm system were in place in the designated centre and there was evidence of regular and annual checks taking

place. During the walk-around, one inspector noted that there were two external exits from the back garden to access the fire assembly point. One of the gates to access the assembly point was blocked by a large rock. This meant that this gate could not be opened to access the assembly point. The inspector went to the second gate and noted a bag of ice on the ground which was a trip hazard. On opening this gate, the metal handle became stuck. These issues were rectified before the end of the inspection.

Residents and staff demonstrated good practices and awareness of infection prevention and control measures. Residents greeted inspectors with elbow taps and were aware of the need to keep a social distance from those not living in their house. Personal protective equipment and alcohol based hand gels were easily accessible in the centre. A donning and doffing area was provided in the houses. Foot operated waste bins were available to promote safe disposal of personal protective equipment. The person in charge had also completed the COVID19 self-assessment tool which identified actions such as limiting close contact between the person in charge and the CNM1 to ensure continued oversight within the designated centre and addressing identified gaps in staff training by March 2021. Regular audits of PPE stocks and cleaning schedules ensured oversight of the practices within the designated centre.

On review of the designated centre's risk register, it was noted that a number of highlighted risks did not appear to accurately reflect the level of risk in the designated centre. It was also noted by the person participating in management, that the additional control measures in the risk assessments did not reflect the controls that had been put in place to minimise these risks. The person participating in management advised that they would review the risk register after the inspection.

Regulation 10: Communication

The registered provider had ensured that residents were supported to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 11: Visits

The residents were supported to maintain contact with relatives and friends while adhering to public health guidelines.

Judgment: Compliant

Regulation 17: Premises

The premises was clean and designed to meet the aims and objectives of the service. However, some areas both internally required maintenance.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide in respect of the designated centre and had ensured that a copy was provided to residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had policies and procedures in place relating to risk management which included COVID-19 and a process for escalating risk where required. However, further review of the assessment of risk in the centre was required.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider had ensured that residents who may be at risk of a healthcare infection (including COVID-19), were protected by adopting procedures consistent with those set out by guidance issued by the HPSC.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured arrangements were in place for the detection, containment and extinguishing of fires. However, arrangements to ensure ongoing maintenance of escape routes and consistently completing the required fire safety

checks as outlined by the provider's own protocols are completed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Not all personal care plans had been reviewed and updated on an annual basis.

Judgment: Substantially compliant

Regulation 6: Health care

The health and well-being of the residents was promoted in the designated centre. Staff demonstrated a good knowledge of the residents' health care needs and how to support them.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had positive behaviour support plans to guide staff practice and to promote positive behaviour amongst residents. This ensured consistency in the care and support given to residents.

Judgment: Compliant

Regulation 8: Protection

The registered provider had not ensured that all residents were protected from the risk of abuse.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for North County Cork 2 OSV-0003707

Inspection ID: MON-0030998

Date of inspection: 03/02/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Since the inspection a new staff has commenced in the designated centre on 15/2/21. • Following a further consultation with the Allocation Manager three staff were identified through the recruitment process to begin on the following dates within the designated centre 8/3/21, 15/3/21 and 22/3/21. • One staff who was redeployed from another area has requested a permanent move to the area, which is in process. • A further staff review will take place week of 23/3/21 with the Allocations Manager, PIC and PPIM. • Ongoing review meetings with the PIC/PPIM and Allocations officer will be held quarterly in 2021. The focus of these meetings will be: - Ensuring adequate staff to meet the needs of the residents - Planning for any known gaps/resignations or maternity leaves - Planning around annual leave - Effective rostering to meet the needs of people supported - Ensuring the skill mix is correct within the centre . - Any changing needs are highlighted to the General Manager and business cases may be prepared to increase staffing should there be a particular need highlighted.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC has updated the training matrix.	

• Outstanding fire training on the day of inspection; 2 people. Fire training completed for one person. One staff remains outstanding as staff experienced a technical error logging online. Rescheduled training to take place on 23/3/21.
• Manual Handling. All staff have completed HSEland.ie manual handling training. Currently due to COVID-19 restrictions in level 5 face to face training is restricted. This will be reviewed on 5/4/21 and an appropriate plan put in place after this date.
• Outstanding safeguarding training on the day of inspection; 3 persons. Completed 9/2/2021.The PIC has requested additional face to face training for all staff with the Designated Officer. Due to COVID-19 restrictions in level 5 this training is restricted. This will be reviewed on 5/4/21 and an appropriate plan put in place based on the contemporaneous guidelines.
• Positive behavior support training has been identified as mandatory training. Scheduled dates for training online April 8th and April 15th .All staff to have training completed by 15/4/21.
• MAPA Training out of date for seven people. Due to COVID-19 restrictions in level 5 this training is restricted. This will be reviewed on 5/4/21 and an appropriate plan put in place based on the contemporaneous guidelines.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PPIM will visit the designated centre monthly (and more often if necessary).

• The PPIM and PIC will meet monthly to discuss governance in the centre on a 1:1 basis. All aspects of the supports and services within the residences will be discussed. The overall aim of the governance meeting is to ensure a high quality, safe, effective and human rights-based service for all people living in the centre.

• The PIC and PPIM will follow a specific agenda focusing particularly on:

- The rights of people living within the residences: How the centre is responding to upholding people's human rights. Data from the resident's forum will be discussed and action plans for service improvements agreed based on the needs and wishes of the residents. Rights restriction logs will be reviewed and with an aim of minimizing restrictive practices.
- Safeguarding: Safeguarding plans will be reviewed. The PIC will ensure staff are continuously educated around our obligations re: safeguarding the people we support.
- Staffing: Rostering, skill mix and resource requirements within the team will be discussed.
- Training and staff development: The development of a person centred culture and a rights-based approach within the residence will be the primary focus. The training matrix

will be reviewed.
- Risk Management: The risk register will be reviewed and appropriate actions agreed including an audit of existing controls.
- Care planning / personal centred plans: A regular audit of care plans and PCPs will be completed to ensure all are up to date and are focused on supporting the person to achieve their goals, wishes and aspirations.
- Residents' concerns and complaints: Complaints logs will be reviewed. Ensure that residents know their rights around making complaints.
- Health and safety: Maintenance planning, infection control and COVID-19 guidelines will all be reviewed.

To date two monthly meeting has taken place.
The meetings will be documented with an agreed action plan.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC has put up a notice in all three residences to remind the designated staff to inform the PIC of any alarm activation
• Notification of fire alarm activation will be submitted within the quarterly notifications.
• The PIC has a documentation system in place which staff will fill out in case of a notification to HIQA outside of the 3 day notifiable The notebook has a specific list of notifications which all staff have been made aware of by the PIC. Completed on 7/3/2021.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC has updated the complaints procedure to include an up to date easy to read complaint procedure. The procedure also includes an easy to read appeals process. Date completed 4/2 2021.
• There was one outstanding complaint on the date of inspection which has since been closed. The resident is satisfied with the outcome. Date completed 4/2/2021.
• Complaints will be discussed at the monthly governance meeting with PIC/PPIM.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Identified maintenance on day of inspection exposed pipes in bathroom to be completed on 4/5/2021.
• Cupboards to be replaced in kitchen. PIC meeting contractor on 11/3/21 to price replacement.
• Identified designated staff in each residence to contact PIC weekly with any maintenance concerns. This is included on daily schedule log.
• Maintenance will be discussed as part of the governance monthly meetings with PIC/PPIM to ensure timely and preventative maintenance processes are in place.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The PIC and PPIM have reviewed the risk register since the inspection and updated outstanding risks.
• The PIC and PPIM will meet monthly (or more frequently if necessary) to discuss risk management and individual risks within the designated centre. This will ensure clarity around risk ratings as well as risk management strategies.

Regulation 28: Fire precautions	Substantially Compliant

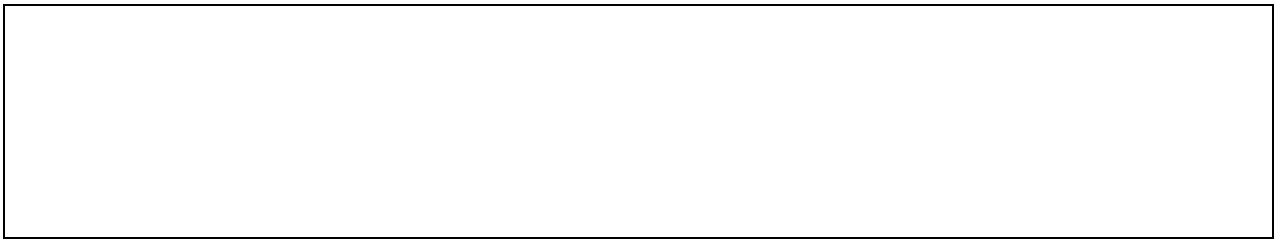
Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC has completed a schedule to ensure adequate reviewing of all fire equipment.
• The PIC will contact the Facilities Manager through the QFM process/ email prior to the date of fire equipment review to ensure equipment is reviewed in a timely manner.
• The daily checks record book has been updated to also include fire exits externally. As part of the daily checks, the designated person on duty will complete a walk around the premises and record / report any concerns to PIC /PPIM. The PIC and PPIM will discuss the process on their monthly governance meeting agenda or sooner if applicable. Completed on 7/3/2021.

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:
• The PIC has completed a schedule of review of all residents' individual risks and personal plans. The PIC and PPIM will review schedule of plans on a monthly basis at the governance meeting to ensure all plans are up to date. To be updated by 30/4/2021.
• On the date of inspection one care plan had not been reviewed since January 2020. This has since been reviewed on 7 7/3/2021.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Outline how you are going to come into compliance with Regulation 8: Protection:
The registered provider shall protect residents from all forms of abuse. -The PIC has spoken to all staff in the designated centre and advised staff to report all concerns in relation to any incident, allegation or suspicion of abuse. A culture of zero tolerance will be fostered within the residence. The person in charge will follow the correct procedures when dealing with any issue of concern under the safeguarding and trust in care policies as appropriate. The safety, health and well-being of all residents will be the primary focus in fostering a culture of reporting concerns. The PIC will follow all recommended guidelines in relation to reporting to HIQA within 3 days, NIMS and HSE safeguarding. As well as reporting to PPIM and Designated Officer. - There is a 24/7 governance arrangement in place for any concerns outside of when the PIC is rostered. This has been communicated clearly to all staff. The PIC will follow all recommended guidelines; ensuring the safety of the resident, informing the PPIM and designated officer as well as reporting concerns to HIQA within 3 days, completing NIMS and report to HSE Safeguarding Team.
- All staff have completed online HSEland.ie safeguarding. The PIC has been in contact with the Designated Officer within Cope Foundation to also arrange face to face training once level 5 COVID -19 restrictions eased on 5/4/21. To be completed by 30/6/2021.
- The PIC has established a local protocol for each residence on safeguarding completed on 9/2/2021.
- Safeguarding Residents from abuse will be discussed as a standing agenda item at the monthly governance meetings between PIC/PPIM. Appropriate actions will be taken to ensure that the team are fully aware of their responsibilities around safeguarding on an ongoing basis.
- A safeguarding issue of concern remains open under the Trust in Care Policy . To be completed by 30/4/2021



Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/06/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/06/2021

	are of sound construction and kept in a good state of repair externally and internally.			
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	07/03/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	07/03/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	23/03/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the	Not Compliant	Orange	07/03/2021

	following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(b)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which the fire alarm equipment was operated other than for the purpose of fire practice, drill or test of equipment.	Not Compliant	Orange	07/03/2021
Regulation 31(3)(f)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any other adverse incident the chief inspector may prescribe.	Not Compliant	Orange	07/03/2021
Regulation	The registered	Substantially	Yellow	04/02/2021

34(2)(e)	provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Compliant		
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	30/04/2021
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	30/04/2021
Regulation 08(2)	The registered	Not Compliant	Orange	30/04/2021

	provider shall protect residents from all forms of abuse.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	09/02/2021
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	30/06/2021