Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 18
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	22 October 2019
Centre ID:	OSV-0005628
Fieldwork ID:	MON-0024179

About the designated centre

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

A full-time residential service is provided for adults with an intellectual disability in Cork City North 18. The centre comprises two bungalows located on a campus in an inner city suburb of Cork city. There are two other designated centres comprising five houses, and a day service also located on the campus. A maximum of 18 people can live in the centre. On the day of inspection there were seven people living in one bungalow, and nine in the other. Both bungalows were purpose built and are accessible to all including accessible bathroom/shower facilities. The communal spaces in each house included a large sitting room, a spacious sun room, a separate dining room and a kitchen. The centre was staffed at all times, with a minimum of three staff in one house and two in the other by day. Each house had one waking staff member from 20:30 to 08:30, with one additional nursing staff member working by night in this and a neighbouring centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
22 October 2019	09:45hrs to 19:30hrs	Caitriona Twomey	Lead
22 October 2019	09:45hrs to 19:30hrs	Margaret O'Regan	Support

What residents told us and what inspectors observed

An inspector met with six of the seven residents in one of the houses. The majority of residents were non-verbal communicators. Two residents accompanied an inspector and member of staff as they walked around the house. Later one of the residents spent more time with the inspector speaking about their plans for the upcoming weekend and other things that were important to them. When the inspector arrived in the house four residents were out swimming. Upon their return, they gathered in the dining room awaiting an evening snack. Some residents were scheduled to go to a social event that evening. There was a very calm atmosphere in the house and there were no obvious signs that residents did not get on well with each other. This had been a reported issue previously. All residents appeared at ease in each other's company and with the staff on duty. Some residents were observed smiling during interactions with staff and the inspector.

An inspector met with the nine residents of the second house. Residents who communicated verbally, told the inspector about their day, their planned outings and spoke about their families. Other residents communicated with the inspector non verbally by sitting with the inspector and walking with the inspector as she was shown around their home. The inspector noted the manner in which residents interacted with staff and the ease at which these interactions occurred. Residents spoke about their home what they liked such as their bedrooms. The inspector saw the pride residents had in their environment when they invited the inspector to see their personalised bedroom.

Capacity and capability

It was evident that improvements had been made in the management systems in the centre. These improvements resulted in an improved quality of life, and a safer home, for residents. Although progress had been made, continued improvement was required to ensure a consistent and effective delivery of care and support for residents.

A new person in charge had been appointed since the last inspection of the centre. This person fulfilled the role for two centres, comprising of three houses. According to the statement of purpose, they dedicated half of their working week to this centre. This person was on leave on the day of the inspection. When asked who was completing the roles and responsibilities of the person in charge in their absence, inspectors were informed that the person in charge of the other designated centres on the campus and other management staff were available to the staff teams in the two houses. The nominated person participating in management of the centre was also available and based on the campus. It became apparent throughout the

inspection that this broader management structure was involved in the day to day running of the centre. Although reflected in some documentation in the centre, this was not reflected in the organisational structure outlined in the statement of purpose.

Inspectors were informed of a number of initiatives that had been implemented in the centre since the last inspection. These included the appointment of house leaders, the systematic review and where appropriate removal of restrictive practices, the introduction of weekly information sessions for staff on key topics (for example advocacy, the keyworker role, support plans), a review of the staff mix in each house, the enhancement of the keyworker system, the development of an induction book for new staff, and the continued focus on increased participation and engagement in meaningful activities for residents. Inspectors were also informed of another initiative, at the early stages of development, to make the advocacy forums in the centre more meaningful for residents by tailoring them to their communication needs.

The inspector reviewed the annual review of the centre and the two most recent six-monthly visit reports completed by a representative of the provider. The annual review was completed in November 2018. There was no evidence of consultation with residents or their representatives in the annual review, as is required by the regulations. The two six-monthly visit reports were completed in June 2018 and April 2019. There was no documented plan to address the concerns regarding the standard of care and support in the centre identified in the June 2018 report. The more recent report was comprehensive and identified a number of the issues identified during this inspection. These included that the fees to be charged to residents were not clearly outlined in the written contract, and that person centred planning meetings and associated documentation required improvement. There were two documented reviews of the plan developed following the April 2019 unannounced visit. These demonstrated the actions taken by staff to address the identified issues and what work remained outstanding. A third review had been scheduled for the week prior to this inspection but had to be rearranged due to unforeseen circumstances.

A random sample of five contracts of care were examined by the inspector. The fees to be charged were not clearly outlined. As mentioned above, this issue had been identified in the provider's own audit but had not been addressed. In addition to the absence of the fees to be charged, inspectors also identified other issues with the written contracts. A number of them were not dated. The use of white correction tape was observed on one contract. There was also a reference to 'appendix 1', however this appendix was not attached to any of the contracts reviewed.

Inspectors reviewed the recorded incidents in the centre. In the majority of cases, the person in charge had informed the chief inspector in writing of the occurrence of adverse incidents in the centre. However, it was identified that in the reports provided at the end of each quarter of the calendar year not all injuries to residents were included. As will be discussed later in this report, not all restrictive practices in use in the centre had been identified. As a result their use was not included in the

quarterly notifications, as is required by the regulations.

Efforts had been made to maintain regular staff teams in each house. Members of the management team reported that, for the most part, this was successful. Some new recruits to the organisation had started, and continued to work, in this centre. An inspector spoke with one of these members of staff who was positive about their experiences working in the centre and the support they received from colleagues. It was reported to inspectors that at times the proposed staffing complement was not achieved in one of the houses. The planned roster included three staff and one additional staff member to focus on activities during the day. It was reported by members of the management team and staff working in this house that on occasion only three staff were available. While this had no identified impact on residents' safety, it did have a negative impact on residents' opportunities to participate in activities. It was also outlined that on occasion one of the two staff working in the other house would have to leave temporarily to administer medications. It was not clear if this arrangement had a negative impact on residents. It had not been identified as a risk or included on the centre's risk register.

The provider had a training schedule in place for the year. The person in charge could request a place for staff to attend training sessions as required. In addition to the training prescribed by the regulations, there was evidence of access to other appropriate training to support staff's professional development. All of the management team were based on the campus and regularly visited the two houses in the centre. Management also attended a handover meeting held each Friday.

From speaking with staff, the inspector was satisfied they were aware of the complaints management policy and process. Staff were familiar with the need to log all complaints and record the resolution. Each house had a complaints log and the log for one house was examined. The issues recorded were minor and were around clothing. The matters had been resolved locally. Overall, there was a low incident of complaints. It was identified in the six-monthly visit report that the complaints log did not include a section to note if the complainant was satisfied with the outcome of the complaint, as is required by the regulations. A member of the management team had raised this with the organisation's complaints officer, however to date this template had not been revised.

Regulation 15: Staffing

It was identified that at times the staffing provided in one of the houses was not appropriate to the number and assessed needs of the residents. The information and documents referenced in Schedule 2 of the regulations were not reviewed as part of this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

There was evidence that staff had access to appropriate training, including refresher training. Weekly information sessions had also been arranged on the campus to facilitate continuous professional development.

Judgment: Compliant

Regulation 23: Governance and management

While improvements in the governance and management systems in the centre were noted, the non-compliant findings identified in the course of this inspection indicated that further progress was required to ensure the service provided was consistent, safe and appropriate to residents' needs. It was also identified that the last annual review and one of the six-monthly visit reports completed for the centre did not meet the requirements of the regulations.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

A random sample of five contracts of care were examined by the inspector. The fees to be charged were not clearly outlined. A number of them were not dated. The use of white correction tape was observed on one contract. There was also a reference to 'appendix 1', however this appendix was not attached to any of the contracts reviewed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The organisational structure of the designated centre in the statement of purpose was not reflective of the management systems and structures in place in the centre. The arrangements made for dealing with the development and review of residents' personal plans required more detail. The arrangements for consultation with, and participation of, residents in the running of the centre did not reflect all of the systems in place in the centre to facilitate this. The section on complaints required review to ensure it was consistent with the organisation's policy.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The quarterly notifications submitted for the centre did not include all of the required information.

Judgment: Not compliant

Regulation 34: Complaints procedure

Staff demonstrated a good awareness of the complaints policy. Each house had a complaints log. Overall, there was a low incident of complaints. It was identified in the six-monthly visit report that the complaints log did not include a section to note if the complainant was satisfied with the outcome of the complaint. This recommendation, to update the complaints template, had not been acted upon.

Judgment: Substantially compliant

Quality and safety

Over the course of inspection, it was evident that the provider had taken actions to improve the quality of life for residents. It was clear that there was a strong focus on residents' participation in activities in both houses that comprised the centre. It was reported that the majority of residents in the centre had gone on holiday in the last two years. For some residents this was their first ever holiday. Other 'firsts' for residents were also reported. These included a visit to a theatre in Cork city. Staff reported how positive this outing had been for the resident and the staff supporting them. These were significant events for the residents involved and required significant planning and commitment from staff. There were also books in each house full of photographs showing the various activities, outings and social engagements that residents had been involved in in recent months. There was also evidence to suggest that new opportunities were continuously being identified and provided to residents. A staff member spoke with an inspector about a gardening project that was soon to begin in a community allotment.

Inspectors reviewed a sample of residents' files. Overall, the person centred planning documentation required review. As had been identified in the most recent six-monthly visit report, there was a lack of written documentation to evidence family involvement in the planning process. Plans for several residents were

incomplete. For example, plans were not dated, neither was there a date as to when the resident's stated goal was to be achieved. In addition, the person responsible for following up an action to achieve a goal was not always documented, and there were instances where it was unclear what, if any, progress had been made towards achieving the expected goal.

In addition to the outlined documentation issues, there was evidence that residents' individual personal plans were not being implemented. For example, plans for a resident to go bowling had not been achieved. In another instance the notes indicated a resident enjoyed going to the organisation's social club. However, despite this club meeting weekly, the resident appeared to have only attended once in October, and did not attend at all in August. A record of attendance for September was not seen. Records for earlier in the year indicated this resident attended the club once in April. Baking was identified as an enjoyable activity for another resident. However, there was only one recorded instance of this occurring. A similar pattern arose with other listed activities and goals. While some goals would require a significant amount of planning and risk assessment others required very little, for example facilitating a resident to bake.

It was also observed that for one resident although there was no record of an initial planning meeting or the identification of goals, there was information included in the review section of the document relating to two goals. This indicated the possibility that scheduled activities were being retrospectively defined as resident's goals, rather than resident's goals driving the activities provided in the service. Another resident's personal planning goals were 'increased community outings, increased internal opportunities and increased learning opportunities' which made it difficult to establish if the activities referenced in the review section were chosen based on that person's interests and preferences or were what was already available in the service. Overall, the person planning process and its implementation required a more focused, individualised, and accountable approach.

Review of residents' files also identified that a number of assessment and support plans had not been reviewed within the required timeframes. Although there was evidence of annual multidisciplinary review meetings, the records of these contained very little information. The records did not reflect an assessment of the effectiveness of residents' plans. Despite these reviews taking place, there were documents and plans in residents' files that had not been reviewed within the last 12 months, as is required by the regulations. Examples of these included communication profiles, swallowing recommendations and physiotherapy recommendations. It was also identified that some plans, such as intimate care plans, had not been signed. The management team informed inspectors of their plan to review all of the residents' files in the centre by the end of November 2019.

Overall, appropriate healthcare was provided for residents. Healthcare plans were in place. As healthcare needs changed, residents' healthcare plans reflected these changes. There was also evidence of regular review by appropriate healthcare professionals. In addition staff were supported to access training relevant to residents' changing needs. For example, staff had been supported to access specialised training in dementia care as this was an evolving health care issue for

one resident.

From the findings of the previous inspection and through the notification of adverse incidents to the Health Information and Quality Authority (HIQA), it was documented that there had been a number of safeguarding concerns for some of the residents living in the centre. The majority of these concerns were the result of negative interactions between peers. In the seven months prior to this inspection there had been a marked reduction in such incidents. On the day of inspection there were no safeguarding plans open to the Health Service Executive (HSE) Safeguarding Team. Despite this, these plans continued to be routinely reviewed. Members of the management team informed inspectors that they continued to meet monthly with the designated officer to ensure effective oversight of any safeguarding issues. When speaking with staff they were clear on the supports they needed to provide to keep each resident safe. However, it was identified that the documentation in place was not necessarily supporting staff in fulfilling these responsibilities. For example, one of the safeguarding plans that staff spoke about with the inspector was not in the safeguarding folder, while other plans that were included staff believed to be no longer in place.

It was identified during the last inspection of this centre that improvement was required to ensure that restrictions were being applied in accordance with policy and evidence based practice. Following that inspection, an audit of the rights restriction practices used within the centre was completed. The person who completed that audit and subsequent report had since been appointed to a management role in the centre. This person had introduced a new system regarding the implementation and review of restrictive practices. During this inspection, it was identified that this system and associated documentation had been implemented in one house but not fully in the other. On review of the documentation, it was identified that staff required additional training and support to accurately complete these documents and the associated risk assessments. For example, in one house two residents' bedrooms are locked due to the behaviours of their housemates. Neither resident can independently unlock, and therefore, access their bedroom. This was inaccurately rated as a rare or remote risk to these residents' rights. It was also noted that alternative, less restrictive measures were not recorded on the document although there was a section for this purpose. It was therefore not evident that alternative measures had been considered and that the least restrictive measure, for the shortest duration necessary, was used.

Management and direct support staff spoke with inspectors regarding the removal of a number of restrictive practices in the centre. These included residents having access to their own belongings and the replacement of keypads on the front doors with simple switches. These changes were reported to have resulted in an overall improvement in the quality of life experienced by residents. When walking through one of the houses, an inspector identified a number of restrictions that had not been identified as such and were therefore not subject to the appropriate assessment and review processes. These included the use of a keypad to restrict access to the back garden area, locked storage rooms, locked wardrobes in two residents' bedrooms, and no toilet paper in one of the bathrooms. These findings indicated that although progress was made, further improvements were required to ensure that, where

assessed as necessary, restrictions are applied in accordance with evidence based practice.

As previously outlined, it was identified that some risk assessments completed regarding restrictive practices were inaccurate. These findings were replicated when the risk register for the centre was reviewed. It was identified that a number of the risk ratings were not reflective of the risks in the centre. A number of hazards identified in the course of the inspection and their associated risks were not included in the risk register. These included the storage of oxygen and the possible spread of a specific infection. The risk register and the individual risk ratings required review to ensure that they accurately reflected the hazards and level of risk in the centre.

Service and maintenance records for the fire safety systems and equipment in the centre were not stored in the centre or on the campus. Copies of these documents were provided following the inspection and confirmed regular maintenance was completed. An inspector reviewed the fire documentation that was kept on-site for one of the houses. It was identified that a system of daily and weekly fire checks was implemented. Each resident in the centre had a personal emergency evacuation plan. It was identified in these documents that five of the seven residents required direct staff support to safely evacuate the building. There was a record of one drill in night-time conditions involving all seven residents. On review of fire drill records it was noted that drills did not occur monthly, as was specified in the centre's statement of purpose. The drill records were not very detailed. For example, it was not noted which residents participated in each drill or which exits were used. An evacuation time was noted on one record while it was also noted that one resident had refused to leave the building. Therefore the evacuation time noted was not accurate. When being shown around one of the houses it was identified that at least three doors, marked as fire doors, did not appear to have the same seal as others. These doors required review by a competent person to provide assurance that they would be capable of restricting the spread of fire and smoke throughout the building. It was also identified that the door leading from the kitchen to the utility room in one of the houses did not automatically close despite being fitted with a closing mechanism. As a result this containment measure was ineffective.

The houses were spacious and clean throughout. Residents' bedrooms were decorated with personal photographs and other items of their choosing. Some bedrooms were more sparsely decorated than others. The living room, sun room and dining areas were all large spaces with comfortable furniture. When walking through the centre it was identified that some walls needed to be repainted. Bathrooms were also in need of refurbishment with mould evident on the ceilings in two, and an issue with the entire floor becoming wet when the shower was used in another. The couches in the sun room of one of the houses were in very poor condition and required either repair or replacement. Management advised inspectors that these issues had been logged with the organisation's maintenance department the previous year, however had yet to be addressed. It was also noted that it was cold in one of the houses. This had been raised in the last annual review of the centre.

Good facilities were available to ensure residents could bring their own furnishings

to the home. In so far as practicable, most residents were facilitated to retain control over their own clothing and facilitated with adequate laundry arrangements. There was adequate space to store personal possessions. Systems were in place to ensure residents' finances were securely managed and accounted for. The system facilitated residents to access their funds when and as required.

Regulation 11: Visits

There were suitable communal areas in the centre where residents were facilitated to receive visitors in accordance with their wishes.

Judgment: Compliant

Regulation 12: Personal possessions

Good facilities were available to ensure residents could bring their own furnishings to the home. There was adequate space for residents to store their clothes and other personal possessions. Systems were in place to ensure residents' finances were securely managed and accounted for.

Judgment: Compliant

Regulation 13: General welfare and development

Residents have opportunities to participate in activities but not as often as they would like.

Judgment: Substantially compliant

Regulation 17: Premises

While for the most part the premises were clean and comfortable, identified areas that required repair or renovation had not been addressed despite being raised with the provider's maintenance department the previous year.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The system in place for the assessment, management, and ongoing review of risk required improvement. Not all hazards in the centre were included on the risk register and for those that were, many of the risk ratings required review to ensure that they accurately reflected the risks in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

A number of fire doors in the centre and one closing mechanism required review by a competent person to provide assurance that the doors would be capable of restricting the spread of fire and smoke. Records indicated that fire drills had not taken place monthly as is required according to the organisation's policy and centre's statement of purpose. The majority of staff had received training in fire safety. However, records indicated that one had not.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The personal plans for several residents were incomplete. Although multidisciplinary meetings had taken place for residents, there was no evidence that these had incorporated assessments of the effectiveness of residents' plans, as is required by the regulations. In addition, a number of resident's assessments and plans had not been reviewed in the previous 12 months.

Judgment: Not compliant

Regulation 6: Health care

There was evidence that appropriate healthcare was provided for residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Not all restrictive procedures in the centre were subject to assessment and review. It was not demonstrated that alternative measures were considered prior to the use of restrictive procedures or that the restrictions in place were for the shortest duration necessary.

It was identified that six of the 23 staff working in the centre required training in the management of behaviour that is challenging including de-escalation and intervention techniques. There were three sessions of this training scheduled between 24 October 2019 and 28 November 2019. Management informed inspectors that all of these staff were scheduled to attend one of these sessions.

Judgment: Not compliant

Regulation 8: Protection

Staff practice and support in the area of safeguarding was provided to a high standard. However there were issues identified with the associated documentation that did not result in a risk to residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cork City North 18 OSV-0005628

Inspection ID: MON-0024179

Date of inspection: 22/10/2019

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: Staffing levels was entered on the Risk Register on 18/11/2019 as an additional Risk. At all times optimal staffing levels will be ensured. Where staffing shortage occurs due to unexpected circumstance staffing levels will be supported by relief/agency staff. A protocol and procedure was put in place in the centre on 22/11/2019 for when the staff nurse covers medication management for the two houses within the centre. An additional staff nurse was recruited and commenced on 11/11/2019.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A second 6-monthly Review of the Quality & Safety of Care of the centre was completed on 28/11/2019 and contains a documented action plan. The annual Review of the Centre for 2019 is scheduled for completion by 31/01/2020. This review will include consultation with families (via a questionnaire that was posted to all families on 15/10/19) and consultation with residents (via a questionnaire specifically developed for this purpose)	
Regulation 24: Admissions and	Not Compliant

contract for the provision of services	
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: Contract of Care was updated to contain information on fees charged. This was forwarded to all family representatives on 02/12/2019	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Statement of Purpose was updated on 28/11/2019 to reflect the findings of the inspection.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: A system was put in place on 15/11/2019 whereby future quarterly notifications will be reviewed at the Quality & Safety meeting prior to submission to HIQA. This will involve review of incident reports for the quarter, nursing notes and community notes for the quarter, review of incident analysis report for the quarter and review of the draft quarterly notifications.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Local complaints log was updated on 13/11/2019 to note if the complainant was satisfied with the outcome of the complaint. New complaints book were put in place in the centre on 13/11/2019	

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
At all times optimal staffing levels will be ensured. Where staffing shortage occurs due to unexpected circumstance staffing levels will be supported by relief/agency staff whenever possible thus ensuring minimal impact on the activity staff role within the centre. Each keyworker will be provided with guidance on completing a person centred planning meeting and with supporting residents to access their preferred activities on a regular basis.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Bathroom ceilings were cleaned by outside contractor on 12/11/2019. The requirement for painting was highlighted to facilities and is scheduled to be completed by 31/01/2020. Replacement couches have been sourced and are currently being requisitioned. With regard to the bathoom, where the entire floor becomes wet when the shower is used, this has been escalated to facilities for review in early 2020.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Site Specific Risk Register was updated on 18/11/2019 to include the storage of oxygen and possible spread of a specific infection. As part of this update all existing risk ratings were reviewed in relation to all documented incidences which occurred within the Centre for the previous 12 months

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A schedule of monthly Fire drills is in place. House leaders will be requested to document these Drills to ensure to detail these correctly. Fire book audits will be completed quarterly at safety & quality meetings. Fire door in utility room was repaired on 21/11/2019. The three doors, marked as fire doors, which did not appear to have the same seal as others, were repaired on 25/11/2019. Staff member requiring fire safety training is awaiting a place on the next available fire safety training course for December 2019.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Keyworker list was reviewed and updated on 26/11/2019. Each keyworker is to be met for guidance on completing a person centred planning meeting and documenting goals. From this process families will be contacted to schedule a person centred planning meeting. This will be completed by 31/01/2020. Communication profiles and intimate care plans were reviewed, updated and signed accordingly on 27/11/2019. Swallowing recommendations for all residents will be reviewed a part of the process of changing from Irish consistency descriptors to international descriptors. This is scheduled to be completed by 01/04/2020.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Restrictive procedures in the centre were reviewed on 27/11/2019. A procedure for the reduction of restrictive practices is in place following review and scheduled to be reviewed again on 27/02/2019. Additionally, a further review of restrictive practices will form part of the annual review of the quality and safety of care scheduled for completion by 31/01/2020. Training in the management of behaviour that is challenging including de-escalation and intervention techniques is scheduled for 05/12/2019. Further training is scheduled for December 2019 and January 2020 until full compliance is achieved.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/01/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	22/11/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the	Substantially Compliant	Yellow	31/01/2020

	designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/01/2020
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	31/01/2020
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide	Not Compliant	Orange	31/01/2020

	for consultation with residents and their representatives.			
Regulation 23(2)(a)	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 frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	28/11/2019
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	02/12/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Not Compliant	Orange	18/11/2019

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	25/11/2019
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	31/12/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the	Not Compliant	Orange	15/11/2019

	procedure to be followed in the case of fire.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	28/11/2019
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	15/11/2019
Regulation 31(3)(d)	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 injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	15/11/2019

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.	Substantially Compliant	Yellow	13/11/2019
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	01/04/2020
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in	Not Compliant	Orange	31/01/2020

	accordance with his or her wishes.			
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with 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.	Not Compliant	Orange	31/01/2020
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.	Not Compliant	Orange	01/04/2020
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	Substantially Compliant	Yellow	31/01/2020

	intervention techniques.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	31/01/2020
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	31/01/2020
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	31/01/2020