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

Issued by the Chief Inspector

Name of designated centre:	No 11 Ard Na Greine
Name of provider:	Peter Bradley Foundation Company Limited by Guarantee
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	06 April 2021
Centre ID:	OSV-0001522
Fieldwork ID:	MON-0031739

About the designated centre

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

No 11 Ard Na Greine consists of a detached dormer bungalow located in a small town. This designated centre provides a residential neuro-rehabilitation service for five residents with an acquired brain injury. Both male and females over the age of 18 can avail of the centre. Each resident in the centre has their own bedroom and other rooms in the centre include bathrooms, a kitchen/dining area, a sitting room and staff rooms. Residents are supported by the person in charge, a team leader and rehabilitation assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Tuesday 6 April 2021	10:10hrs to 16:00hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

From what residents told the inspector and what was observed, residents were being actively supported to develop their independence and recover from a brain injury in a person-centred way. However, the premises provided was not suited to residents' needs

This inspection occurred during the COVID-19 pandemic with the inspector adhering to all national and local guidelines. Social distancing was maintained when communicating with residents and staff while personal protective equipment was used. On arriving at the centre the inspector was greeted by the person in charge who requested a number of COVID-19 checks to ensure that the safety of those present in the centre was maintained.

During the inspection it was seen that efforts had been made to present the premises in a homely manner with various examples of photographs, drawings and residents' artwork on display It was observed though the premises did not adequately support the needs of all residents. For example, it was seen that communal space for residents was limited given the number of residents living in the centre and the overall size of the premises. In addition, there was a wheelchair user living in this centre and parts of the premises did not promote accessibility such as the downstairs bathroom area and the absence of lowered food preparation areas in the kitchen which reduced this residents' independence.

However, throughout the inspection it was observed that there was a positive, warm and relaxed atmosphere present in the centre. There appeared to be good relationship between the person in charge, staff and residents who engaged well together. Two members of staff were spoken with during the inspection, both of whom displayed a good knowledge of residents and what supports they required. It was noted that that that there as a strong consistency of staff support which helped to ensure consistent care and professional relationships.

The inspector had an opportunity to meet with all five residents who lived in this centre. All residents were able to communicate verbally and some residents discussed with the inspector their lives in this centre. One resident said they loved living the designated centre and liked the support they got from staff members. They also talked about some of this things they liked to do such as meditation, using a computer/tablet device and mindfulness colouring. This resident spoke to the inspector about their family and talked about how they had met a family member for a visit outdoors in line with national guidance.

Another resident talked about how they were getting tired of the restrictions that were in place due to COVID-19 but mentioned that they recently had a birthday and received a window visit from their family who brought presents and a birthday cake. This resident also spoke positively about staff and the card games that they liked to play. A third resident spoken with briefly talked about being supported to attend a

medical appointment with a staff member on the day of inspection.

Feedback that had been submitted by residents as part of the centre's annual report consultation process was reviewed. For this residents had been explicitly asked their views on key matters relating to the running of the designated centre that impacted their quality of life. As such residents were queried on their rights, their meals, visitors, their overall care and support, staff and activities. Generally positive feedback was received for such areas.

In this annual review residents were also asked about their view on the premises provided and their individual bedrooms. Again residents generally gave positive feedback about this matter although one resident indicated unhappiness about the amount of storage they had in their bedroom for their belongings. It was noted during this annual review that one resident commented "I'd like a bigger house with better access for my wheelchair" and "I'd also like better facilities so that I can help with cooking and do other activities – to be able to learn myself and live as independently as possible"

Arrangements had also been made to obtain feedback from residents' family members and it was noted that six compliments had been received from family members commenting positively on the overall support given to residents by staff and for facilitating visits. It was seen that a sheltered area in the rear garden was available for visitors with window visiting and meetings in outdoor public places facilitated. During the COVID-19 pandemic all residents had been supported maintain contact with family members via telephone, WhatsApp and Zoom. In the annual review one resident had praised staff's role in helping visiting by saying "Staff are excellent, my visitors comment on how welcome they feel".

Another comment made by a resident during the annual view was that they liked their bedroom because it afforded them privacy. Throughout the inspection it was seen that residents were treated respectfully by staff with information on residents' rights on display in the centre. Residents were being given information and consulted on the running of the designated centre through monthly resident meetings. The occurrence of these meetings was in keeping with the residents' guide and centre's statement of purpose that were both available for residents in the centre. It was seen during these meetings that residents were facilitated to have an in depth discussion about particular topics such as COVID-19 vaccines or the premises.

The centre promoted a restraint free environment and throughout the inspection, no restrictive practices were witnessed by the inspector. During the inspection one resident left the centre on their own to go for a walk around the nearby area. Promoting residents' independence was in keeping with the supports being given to residents intended to aid residents' recovery from their brain injuries. For example, some residents held their own bank cards and did all their transactions independently while others managed their own medicines. Where supports were needed around such areas it was provided. Residents participated in their own meal preparation and during the inspection one resident supported staff in baking scones. Staff had also began to encourage residents to plant seeds in the back garden. One

resident spoke of this while another resident was seen to participate in this during the day.

In summary, the inspector found that the service provided to residents was geared towards aiding their recovery from brain injuries and improving their independence. This helped to promote residents' overall welfare and wellbeing. The inspector found that there were systems in place to ensure residents were safe and in receipt of good quality care and support. However, the premises was not suited to the needs of all residents and improved premises could further enhance the service that was already being provided to residents.

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

Capacity and capability

Overall the management systems in place were supporting residents in line with the aims of the centre and the provider to support residents to recover from brain injuries. However, a longstanding issue relating to the suitability of the premises provided had not been addressed at the time of this inspection.

This designated centre was registered until July 2021 and had last been inspected by HIQA in September 2019. That inspection had found an overall good level of compliance aside from the premises which was not suitable for the assessed needs of the residents while a plan to address this had not sufficiently progressed. In response to this the provider outlined, in their compliance plan response, a clear plan for addressing this which involved residents moving to a new premises by March 2021.

Updates received before the current inspection indicated that this plan had been delayed and as such the premises remained unsuited to meet the needs of residents. It was acknowledged that this was influenced by the COVID-19 pandemic and design issues with the intended new premises. However, during this inspection there was no clear indication as to when a new premises would be available and it was noted that the provider had taken out a new three year lease for the current premises.

Concerns around the suitability of this premises had first been raised by an HIQA inspection in February 2015 as well as further inspections in December 2015, November 2016 and January 2018. While the provider had made adjustments to the premises over the years and was making efforts to provide a new premises, under the regulations the responsibility to ensure that the designated centre was appropriate to residents' needs lay solely with the registered provider. Sufficient progress had not been made over a 6 year period to ensure that the current

premises was suitable to meet residents' needs.

Issues relating to the premises were highlighted in a health and safety review conducted by the provider and were also referenced in the management systems that were used to monitor the services provided to residents. Such systems included completing provider unannounced visits to the centre to review the quality and safety of support provided to residents. Reports of two such visits carried out during 2020 were reviewed which focused on key aspects of the services provided to residents. It was noted that these focused on a variety of areas impacting residents including, nutrition, residents' rights, safeguarding and COVID-19.

The provider had also ensured that an annual review of the centre had been carried out for 2020 and it was noted that that it had a heavy emphasis on feedback from residents themselves. Provision was also made for feedback from family members. Where any areas for improvements were identified by the either the provider's annual review or unannounced visits, an action plan was put in place to respond to such issues with responsibility assigned to ensure that such actions were completed.

It was seen that responsibility for such actions was sometimes assigned to the person in charge who was met during this inspection. They commenced in this role in November 2020 and was suitably qualified and experienced to perform the role. During this inspection, the person in charge demonstrated a good understanding of the needs of the residents and the supports they required along with the overall operations of the centre. The person in charge had ensured that all of the information requested for this inspection was available for review.

In addition to this designated centre the person in charge was also involved in some community-based services run by the provider and was supported in the running of the centre by a team leader with the remainder of the staff team made up by rehabilitation assistants. The staffing arrangements in place to support residents were appropriate for the assessed needs of residents and, despite restrictions imposed by the COVID-19 pandemic, arrangements had been made to ensure that staff were provided with appropriate training so that they had the necessary skills to support residents. It was evident from rosters maintained in the centre that there was a strong continuity of staff support for residents.

Regulation 14: Persons in charge

The person in charge had appropriate qualifications and ample management/supervisory experience to perform the role in line with the requirements of the regulations. The person demonstrated a good knowledge of the residents and the operations of the centre.

Judgment: Compliant

Regulation 15: Staffing

Appropriate staffing arrangements were in place to support residents' needs in line with the designated centre's statement of purpose. Staff rosters were appropriately maintained in the centre and a continuity of staff was provided to support residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that a range of training was provided to staff in areas like fire safety, first aid, manual handling and PPE. When any staff required refresher training this was arranged.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not made sufficient progress in ensuring that the designated centre was appropriate to residents' needs with regards to the premises provided. This had been first highlighted as a concern by HIQA in February 2015.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose was in place that included all of the required information. Based on the overall findings of this inspection, the statement of purpose accurately described the services and supports that were being provided to residents. The statement of purpose was available in the designated centre and had been recently reviewed.

Judgment: Compliant

Regulation 34: Complaints procedure

Information on how to make complaints was on display in the centre. The provider helped ensure that residents were supported to raise complaints. For example, one resident raised a matter during a residents' meeting which was managed appropriately through the complaints process. A record of any complaints made was kept including details of how such complaints were responded to.

Judgment: Compliant

Quality and safety

Residents were being supported to enjoy a good quality of life while measures were being taken to limit the potential impact of COVID-19 although the premises remained unsuitable to meet the needs of all residents.

As required under the regulations all residents had a personal plan outlining their needs and how these were to be met. These plans were subject to regular review and, given the nature of residents' needs generally, a key focus of these plans was on supporting residents to recover from their brain injuries. As such residents were supported to develop their life skills and independence in various ways such as improving their cooking skills and the management of their own medicines. It was seen that one resident had a long term goal to leave the designated centre and live independently with support being given to this resident to achieve this.

The residents' personal plans also contained information on how to support residents with their health needs if required. Where any resident had a specific health need, it was seen that specific plans of care were put in place to support residents with these. Access to allied health professionals such as psychologist and speech language therapist were supported while on the day of inspection it was seen that one resident was supported to attend their general practitioner.

While such measures were in keeping with meeting residents' needs, the premises in place was not suitable to meet the accessed needs of all residents. For example, the hallway and doorways were narrow, which did promote ease of movement for a resident using a wheelchair. In addition, the absence of lowered food preparation areas in the kitchen reduced this resident's independence while the layout and size of downstairs bathroom used by most residents was not suited to a wheelchair user. Given the overall size of the premises and the number of residents living there, there was limited communal space while the inspector was also informed that the needs of some residents were increasing and more space would be needed for particular equipment to support such changes.

However, it was seen that the premises was presented in a homely manner with various photos and drawings on display. It was also noted that each resident had their own bedroom for privacy and throughout the inspection staff were seen to engage with residents in a respectful manner. Residents were consulted in relation to the running of the designated centre both individually and collectively through

monthly resident meetings. These meeting were outlined in the residents' guide that was in place in this designated centre. Such a guide is required by the regulations and it was seen that it contained all of the required information such how to access HIQA inspection reports.

It was also evident that appropriate measures had been taken to ensure that residents were safeguarded from any potential abuse. When concerns did arise they were responded to with protective measures put in place where necessary and the appropriate bodies notified. It was also seen that all staff members working in the designated centre had received relevant training on safeguarding and how to respond to any concerns. Guidance was available for staff in residents' personal plans on to safeguard residents and preserve their dignity in the event that residents' needed support with intimate personal care.

The provider had also taken steps to ensure that residents were protected from COVID-19. Risk assessments concerning the designated centre and individual residents had been updated to take account of COVID-19. The provider had completed a COVID-19 outbreak preparedness and contingency planning self-assessment issued previously by HIQA. There had also been has been significant input into increasing infection prevention and control processes within the centre. For example, an increased schedule of cleaning had been implemented.

In response to the COVID-19 pandemic it was noted that staff had been provided with training in relevant areas such as infection prevention and control, hand hygiene and the use of PPE. On the day of inspection it was observed that all staff members were wearing appropriate PPE while cleaning was also observed to take place. It also was noted there was regular temperature checking of staff while they were on duty while residents were also monitored for any symptoms. As part of the contingency plan in place residents, in the first instance, would be supported to self-isolate within the centre if required. While it was noted that the layout and size of the premises could make this difficult, it was seen that since the beginning of the COVID-19 pandemic none of the residents had contracted COVID-19 owing to the infection prevention and control measures put in place.

Regulation 13: General welfare and development

Residents were supported to maintain contact with their families and to participate in various activities such as baking, seed planting, mediation and mindfulness colouring.

Judgment: Compliant

Regulation 17: Premises

The premises was not suited to meet the needs of all residents and did not consistently promote accessibility in line with best practice. Communal space was limited given the overall size of the premises and the number of residents living in the centre.

Judgment: Not compliant

Regulation 20: Information for residents

A residents' guide was in place that contained all of the required information such as a summary of the services and facilities provided along with how to access HIQA inspection reports. The residents' guide was on display in the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

As part of the risk management process in operation within this designated centre, relevant risk assessments had been updated in relation to COVID-19. A risk register was in place that was regularly reviewed.

Judgment: Compliant

Regulation 27: Protection against infection

Measures were taken to ensure that residents were protected by appropriate infection prevention and control measures. These includes regular cleaning, the use of PPE and staff temperature checks.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

All residents had a personal plan in place which was subject regular review. Residents had individualised goals in place which were intended to promote their independence and recovery from brain injuries. It was seen that residents were making progress with their goals.

Judgment: Compliant

Regulation 6: Health care

The health needs of residents were appropriately supported. For example, residents had specific plans in place for identified health needs and access to allied health professionals where necessary.

Judgment: Compliant

Regulation 8: Protection

All staff had been provided with safeguarding training and any concerns that were raised were responded to appropriately. Intimate care plans were also in place where necessary.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were actively consulted on the running of the designated centre and were observed to be treated in a respectful manner throughout the inspection.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for No 11 Ard Na Greine OSV-0001522

Inspection ID: MON-0031739

Date of inspection: 06/04/2021

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
In order to come into compliance with regulation 23 the provider has put following plan in place:

Current Premises

Assessment and Review

An Occupational Therapy review was completed on 24/5/21 with recommendations provided on 25/5/21.

An Architect review of the house was completed on 26/5/2021 and recommendations were received on 27/5/2021.

Estimated costings for these works were submitted to management on 27/5/2021.

A full disability access review was completed on 28/5/2021 to support the above recommendations.

Funding and approval

An outline funding application was submitted to MM Disability Manager HSE, and approval was received on 27/5/2021.

The Landlord viewed the house on 31/5/2021 and the upgrade works were detailed to him he agreed with the completion of same.</td></tr>
</table>

Plan of works

The following is currently being undertaken:

• Outline plan as per instructions agreed on 27/5/2021.
• The finalized detailed work plan will be completed by 4/6/2021.
• A construction company will be identified and engaged following a tender process if appropriate (for completion by 30/7/2021 as per architect guidance).
• Works to be coordinated and completed ensuring the least possible disruption to residents. These will take place on a phased basis and residents will be supported on short breaks during completion of work (estimated completion by 5/11/2021 as per architect guidance, allowing for any delays final expected completion date 11/2/2022).

Timeframe for completion of works

Minimizing disruption to the residents will impact on the lead in time and this is reflected in the timeline given a 6-week work plan is expected this has been extended to 14 weeks to minimize disruption. In addition, a contingency of 12 weeks has been added to the full completion date to allow for any unforeseen issues arising and for snag list completion.

Completion of works is expected by 11th February 2022.

Building Occupancy

The above works once complete will meet the current needs as identified through the Occupational Therapy review and will future proof the house regarding changing needs of the current residents as identified by the architect.

In line with Acquired Brain Injury Ireland Policy and Regulation any new admission to the designated center will be subject to a comprehensive assessment, by an appropriate healthcare professional to identify their health, personal and social care needs.

After this assessment process it will be identified whether an individual’s needs can be met in line with the statement of purpose of the designated centre taking into consideration the available accommodation prior to admission.

Admission to the designated centre will be subject to meeting the above requirements.

Communication

The PIC via the PPIM will update the CEO on a regular basis (monthly at a minimum) in relation to the progress of the works.

New Build

The providers CEO has written to Cork County Council requesting a comprehensive and formalized plan with agreed schedule of works and timeframes for transition to new premises to be identified. The response to this request was received on Friday 23rd April.

The providers Senior management will continue to liaise with the Cork County Council and Tuath Housing on a quarterly basis to ensure that agreed targets are met and progress maintained.

The process below was formally commenced on 30/3/2021 with the following projected timeframes attached:

• Stage 1 – Approval to design the project (30/6/2021)
• CAS 1 form submitted
• 75 weeks begin once a valid application is with Dept.

• Stage 2 – Approval of initial designs (preplanning) (23 weeks – 10/12/2021)
•Include site surveys/investigations
• Expected to take AHB 17 weeks to submit stage 2 to LA. 6 weeks for reply.

• Stage 3 -Seek permission to tender for the main works (26 weeks – 10/6/2022)
•Detailed design and cost plan
•Maintain cost control
•Stage 3 application to LA expected 20 weeks after Stage 2 approval. Decision expected 6 weeks later

• Stage 4 – Approval of tendered project (21 Weeks - 4/11/2022)
•Demonstrate adequate procurement process.
•Stage 4 expected 12 weeks after Stage 3 approval. 5 weeks for approval. Further 4 weeks allowed to get on site.

The CAS process should take 75 weeks for completion, however, allowing for any delays during this process a further 26 weeks have been added to give an estimated completion date of 31st May 2023.

With respect to the build time once on-site, if the house is prioritised for completion at tender stage this could indicate a 13 month build time.

That gives us an indicative date for practical completion of 30th June 2024.

Quarterly feedback will be given to the PIC to ensure residents are updated regarding any changes or progress made with the new build project.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Current Premises

In relation to Regulation 17 (1)(a): The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents and Regulation 17 (7) The registered provider shall make provision for the matters set out in Schedule 6.

These regulations will be met through the following:

Assessment and Review

An Occupational Therapy review was completed on 24/5/21 with the following recommendations provided on 25/5/21:

- Interior and exterior doors to be widened to increase accessibility.
- Kitchen to be adapted to meet the needs of all individuals in the house, specific recommendations were made regarding layout and accessibility.
- Bedroom configuration and use to be reconsidered in line with the needs of the individuals in the house.
- Downstairs bathroom upgrade works identified.

An Architect review of the house was completed on 26/5/2021 and the following recommendations were received on 27/5/2021:

- Widening and repositioning of doorways in downstairs rooms.
- Kitchen adaptations to provide a fully accessible kitchen which will meet the needs of all residents.
- Adaptations to the current main bathroom and an addition of an extension to add a fully wheelchair accessible bathroom to the house which would in future be hoist accessible.
- Adaptation to the front and rear entrances of the house providing permanent ramps and widened doorways.
- Upgrade to windows upstairs to provide fire evacuation points.
- The addition of an outdoor cabin/seomra which will provide an additional multi-purpose communal space for residents.

Estimated costings for these works were submitted to management.

A full disability access review was completed on 28/5/2021 to support the above recommendations.

Funding and approval

An outline funding application was submitted to MM Disability Manager HSE and approval was received on 27/5/2021

The Landlord viewed the house on 31/5/2021 and the upgrade works were detailed to

him he agreed with the completion of same.

Plan of works

The following is currently being undertaken:

• Outline plan as per instructions agreed on 27/5/2021.
• The finalized detailed work plan will be completed by 4/6/2021.
• A construction company will be identified and engaged following a tender process if appropriate (for completion by 30/7/2021 as per architect guidance).
• Works to be coordinated and completed ensuring the least possible disruption to residents. These will take place on a phased basis and residents will be supported on short breaks during completion of work (estimated completion by 5/11/2021 as per architect guidance, allowing for any delays final expected completion date 11/2/2022).

Timeframe for completion of works

Minimizing disruption to the residents will impact on the lead in time and this is reflected in the timeline given a 6-week work plan is expected this has been extended to 14 weeks to minimize disruption. In addition, a contingency of 12 weeks has been added to the full completion date to allow for any unforeseen issues arising and for snag list completion.

Completion of works is expected by 11th February 2022.

In relation to 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. This regulation will be met as detailed above with the addition of the following:

Building Occupancy

The above works once complete will meet the current needs as identified through the Occupational Therapy review and will future proof the house regarding changing needs of the current residents as identified by the architect.

There will be further review from Occupational Therapy regarding the appropriateness of the service for each resident to ensure all needs are identified and met within the statement of purpose for the designated centre.

Residents will continue to engage in the Individual Rehabilitation Planning process and any changing needs will be identified, assessed, and planned for through this process.

In line with Acquired Brain Injury Ireland Policy and Regulation any new admission to the designated center will be subject to a comprehensive assessment, by an appropriate healthcare professional to identify their health, personal and social care needs.

After this assessment process it will be identified whether an individual’s needs can be

met in line with the statement of purpose of the designated centre taking into consideration the available accommodation prior to admission.

New Build

The providers CEO has written to Cork County Council requesting a comprehensive and formalized plan with agreed schedule of works and timeframes for transition to new premises to be identified. The response to this request was received on Friday 23rd April.

The providers Senior management will continue to liaise with the Cork County Council and Tuath Housing on a quarterly basis to ensure that agreed targets are met and progress maintained.

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That gives us an indicative date for practical completion of 30th June 2024.

Quarterly feedback will be given to the PIC to ensure residents are updated regarding any changes or progress made with the new build project.

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/06/2024
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	Not Compliant	Orange	30/06/2024

	to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2024