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 South 4
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	01 November 2021
Centre ID:	OSV-0003296
Fieldwork ID:	MON-0034740

About the designated centre

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

Cork City South 4 provides residential and respite accommodation for female adults, with a mild to moderate intellectual disability. The building is detached and located in a corner site in a quiet residential estate, adjacent to a green area. Overnight accommodation consists of two twin bedrooms, and two single rooms. Downstairs there is a staff bedroom, with an en-suite bathroom. The living area has a front room, dining/sitting room and a kitchen. There is a small patio area at the rear of the building, which is enjoyed by residents for relaxation and leisure when the weather is fine. Staff supports are provided by health care assistants and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 1 November 2021	09:45hrs to 18:10hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

Overall there was evidence of a lack of leadership and oversight in this centre. Although only recently assigned the responsibilities of the person in charge, the member of the management team that met with the inspector had been involved in the running of the centre for 17 months. Despite this, they were not knowledgeable about the centre and were unclear on where to access information required. Poor governance impacted on the quality of the service provided to the residents and resulted in findings of poor compliance with the regulations relating to governance and management, staffing, protection, training, complaints, and notification of incidents. Despite these findings residents were observed, and reported, to be happy living in the centre. While happy with the activities offered, they did highlight limits placed on their activities by limited resources. It also became clear that improvement was required to ensure that residents had the freedom to exercise choice and control in their daily lives.

This was an unannounced inspection. Within one hour of the inspection starting, the decision was made to complete a risk-based inspection of this centre.

On arrival, the inspector met with a staff member who advised that they and all four residents were about to leave the centre. When the inspector asked if the residents were leaving to attend day services, they were informed that one of the residents would be attending their day service as planned and the other three were attending another day service as there was no staff available to work the daytime shift, outlined on the planned roster. Staff advised that there was also no staff identified to work the same shift on the following day. The inspector originally planned to remain in the centre, contact management, and continue the inspection. However when staff advised that they had been unable to contact their manager despite numerous calls that morning, the inspector left the centre.

Approximately, one hour later, the inspector entered the designated centre with the person participating in the management of the centre. At the time of this inspection they had been in this role for 17 months. There had been a recent change in the management structure of the centre. As a result from one week prior to this inspection, the person participating in management was also fulfilling the responsibilities of the person in charge. In this one week period, the person participating in management had not been in the centre or spoken directly with any of the staff working there. The person participating in management told the inspector that they had not been in this centre for a number of months. Later in the inspection they met the staff on duty, one of four permanent staff working in this centre, for the first time.

Given these initial findings, two immediate actions were issued regarding Regulation 15: Staffing and Regulation 23: Governance and management, requiring the provider to inform the Health Information and Quality Authority (HIQA) in writing by

3pm that day, how they would come into compliance with these two regulations.

The inspector spent time in the centre reviewing documents and speaking with management. Later in the day, they had the opportunity to meet with all four residents and the staff member working that day.

This centre was registered to accommodate six residents at any one time. There were two long-term residents who each had their own bedroom. A respite service was provided in two, twin bedrooms to four residents at any one time. The respite service had been suspended since the beginning of the COVID-19 pandemic. It was identified during this inspection that one 'respite' resident had been living in the centre on a full-time basis since July 2019. The fourth resident, who previously stayed in the centre on alternate weeks, had been living in the centre full-time since the beginning of the COVID-19 pandemic in March 2020. When asked if it was planned to resume the respite service and the practice of sharing bedrooms in the centre, management were not sure. This lack of clarity was reflected in some of the feedback received as part of the most recent annual review of the centre with families expressing their dissatisfaction with communication and uncertainty if there was, or would be, a respite service available to their relative.

The annual review did not include any consultation with, or feedback from, the residents themselves. This is a requirement of the regulations. An annual review had not been completed in this centre in over 12 months. The inspector was informed that one was scheduled for later that week. It was also noted that the unannounced visits to monitor the safety and quality of care and support provided in the centre had not been completed in line with the timelines specified in the regulations. These visits and reports will be discussed further in the 'Capacity and capability' section of this report.

The regulations require that the person in charge notify HIQA within three working days of specified adverse incidents occurring in the designated centre. Prior to this inspection, HIQA had been informed of an incident that a member of the management team had assessed as potentially being a safeguarding matter. This had not been notified to HIQA within three working days. The inspector had requested additional information regarding this matter the week prior to this inspection. As this was outstanding, an update was requesting again during the inspection and was provided later in the day. It was evident that this matter was not followed up within the timelines outlined in the provider's own and the national safeguarding policies. When reviewing the log of incidents in the centre, the inspector identified a number of other adverse incidents that had not been notified to HIQA and, where appropriate, had not been followed up in line with safeguarding policies.

Other documents reviewed included the records of staff training and the complaints log. Significant improvements were required in both of these areas. These will be discussed in more detail later in this report. While the inspector was in the centre, day service staff came to the house to get one of the resident's files. It then transpired that the staff in the day service had identified an issue with the medication records for this resident. Later in the day staff advised that they had

collected an up-to-date prescription and administration record for one resident from their general practitioner (GP) on their way to work that afternoon. This identified another area where management oversight was lacking.

Following their return from day services, the inspector met with all four residents and the staff member working that day. The residents were happy to meet with the inspector and welcomed them into their home. There was a warm and friendly atmosphere with residents regularly laughing and smiling. Each resident expressed that they were happy both living in the centre and with each other. They spoke about recent and planned activities, including a recent three night stay in West Cork. Residents spoke about activities they enjoyed doing while in the house, their favourite musicians, and recent home improvements, including new flooring and repainting the living room. Residents spoke excitedly with the inspector about a new suite of living room furniture that they had chosen and was ordered. New garden furniture had also been bought. Residents told the inspector who they would go to if they had any problems or complaints, who visits them in the centre, and about the fire drills they regularly complete. They also spoke about their resident meetings. Although it was stated in the centre's statement of purpose that these meetings happened monthly, on review of the minutes, the inspector noted that they had not taken place for a five month period in 2021.

When asked how they felt about going unexpectedly to day service that day, all three residents involved reported that they enjoyed their time there. Prior to the COVID-19 pandemic, these residents had attended this day service five days a week. They spoke to the inspector about meeting with friends and catching up on the news from staff and others there. Despite this, one of the residents made it very clear that they did not wish to return to the day service every day and that they preferred the arrangements in place during the pandemic where a staff member came to the house to facilitate activities. The inspector asked if residents ever did activities on their own with staff. One resident spoke about going for a coffee and cake with a staff member after a medical appointment and how much they enjoyed it. The other residents expressed that they would like to go out on their own with staff but could not give any examples of when they had done this. Staff explained that as there was only ever one staff member working in the centre, individual outings were not possible. Feedback documented in the annual review included that one resident was not able to go for a walk some nights as they wished. This appeared to be a longstanding issue in the centre as a complaint had been made by a resident in August 2019 about not being able to go out at the weekend as only one staff was working in the centre.

The inspector had noted when reviewing the minutes of a recent resident meeting that two residents had expressed that they no longer wished to participate in a specific activity. As a result all four residents had stopped attending. Feedback received as part of the annual review referenced a lack of choice in the centre as activities were planned. Residents also spoke with the inspector about the fact that there was no car assigned to the centre. This meant that some activities were either not possible or were limited. Staff told the inspector that a vehicle was borrowed to facilitate the recent West Cork trip but that the plan to have lunch on the way home was impacted by the need to return it by a certain time. When asked how medical

and other appointments were facilitated, staff advised that both staff and transport were requested from other designated centres or day services, or that residents' family members supported them to attend. On review of documents in the centre, the inspector saw a reference to the negative impact of one resident not attending an appointment due to a lack of resources.

The centre was clean, warm and decorated in a homely manner. There were Halloween decorations outside and in communal areas of the house. Following the last HIQA inspection of this centre, the provider advised of plans to build an extension onto this centre. However, these were delayed by the pandemic. This information was provided in response to findings that the private accommodation and number of baths, toilets and showers provided in the centre were insufficient. When asked, management advised that it was still planned to proceed with the extension but they did not know what additional rooms would be provided and when work was to begin. Despite the decision that one resident, following a change in their assessed needs, move to a downstairs bedroom the only bathroom available to residents in the centre was upstairs.

All four residents wanted to show the inspector their bedrooms. At the time of this inspection, due to COVID-19, each resident had their own bedroom. Prior to this, two of the bedrooms in the centre were shared, twin rooms. One of the residents who used to share advised that they did not mind doing this, while the other resident clearly expressed that they did not like it. They had recently moved to a single occupancy room and while happy to have their own room, they were unhappy that their room was "very small". This bedroom was notably smaller than the other three bedrooms. Due to the changing needs of one resident, two had swapped bedrooms. As a result, someone who had previously never shared their room was now in one of the assigned twin rooms, although the second bed had been removed. Each resident had personal items such as photographs and their belongings in their bedrooms. When asked, they said that they had no input into the decoration of their bedrooms and one resident wanted to buy new curtains and have their bedroom repainted. These wishes had been recorded on more than one occasion in the minutes of residents' meetings.

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

Capacity and capability

The provider needed to significantly improve the overall governance and management structure and systems in place to ensure effective oversight and the safe delivery of support to the residents living in this centre. In their written response to the immediate action given regarding Regulation 23: Governance and

management, the provider committed to immediately allocating an experienced manager to work in this centre and fulfil the responsibilities of the person in charge.

As outlined in the opening section of this report, on the inspector's arrival there was confusion regarding staffing and an evident absence of leadership in the centre. When asked, the person participating in management advised that they were only made aware of the staffing vacancy earlier that morning. Staff had a different account and told the inspector that the rosters, including the vacancies, had been sent to the person participating in management weeks previously. They also said that on the previous day, and on the morning of this inspection, they were informed by an on-call manager (the provider has a system in place whereby there is always one manager available to staff in designated centres) that staff would be provided, however this did not happen. The emergency plan for the three residents to go to the day service was arranged that morning during a discussion between the person participating in management and the day services manager.

When in the centre, the inspector reviewed the staff rosters. As already identified, there were two vacancies in the week of the inspection. There was at least one vacant shift every week for the next four weeks. On each occasion it was the 09:00 – 17:00 shift that was not filled. In the provider's written response on the day of the inspection regarding Regulation 15: Staffing, it was outlined that each resident would now attend a day service from Monday to Friday. Staffing would therefore no longer be required in the centre during the day on these days. Management were aware of some residents' expressed wishes not to return full-time to day services. They informed the inspector that the centre was not funded to provide 24 hour staffing and that it was also a challenge to recruit staff across the organisation. The rosters reviewed indicated that that there was only ever one staff member working in the centre. As highlighted in the opening section of this report, this staffing arrangement required all residents to go on outings together and prevented one-to-one support in the community. It also posed challenges when supporting residents to attend appointments.

The inspector reviewed the staff training records available in the centre. Records were available for the four permanent staff but not the relief staff who regularly worked in the centre. It was not clear if the training matrix available was up to date. When asked, the person participating in management thought that there may be a more up to date training matrix but was unable to locate it by the end of this inspection. From the records reviewed three of the four staff required refresher training in both safeguarding vulnerable adults and the safe administration of medication. All four staff required refresher training in epilepsy. This was especially concerning as one of the residents was prescribed emergency medication to treat this condition. Two staff also required refresher training in fire safety. Management was not able to inform the inspector if any of the staff were booked to attend training in any of these areas. Staff supervision had not taken place in this centre in line with the provider's policy.

On review of the complaints log, incident reports, and notifications to HIQA kept in the centre, a lack of oversight and consistency was identified regarding how matters

were recorded and where required, reported to HIQA or other appropriate services.

Lack of oversight meant that similar incidents, such as a resident reporting that either a peer or staff member's behaviour upset or frightened them, were recorded and responded to in different ways. There were at least six similar incidents of this nature involving different residents. On some occasions these reports were recorded as complaints, other times as incidents. If recorded as an incident, the matter may or may not have been considered as a safeguarding issue, and the associated processes followed or not. Only one of these incidents had been reported to HIQA and there was no record of that incident available in the centre on the day of inspection.

When reviewing the complaints log it was identified that a number of complaints remained unresolved and that complainants were not satisfied. The provider's complaints policy stated that unresolved complaints were to be forwarded to the division head who was to ensure investigation and appropriate communication with the complainant. There was no evidence that this policy had been followed regarding these complaints. The inspector also identified that a staff member had recorded a recent complaint in the 2019 complaints log. It was therefore likely that this could be missed by those required to follow up on this matter.

The inspector reviewed the centre's statement of purpose. The statement of purpose is an important document that sets out information about the centre including the types of service provided, the resident profile, the ethos, and both governance and the staffing arrangements. This document had not been reviewed in the previous 12 months, as is required by the regulations. It became clear throughout this inspection, that some of the information contained in this document was not accurate and not reflective of the service being provided in the centre. It therefore required review.

An annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as required. Neither the annual review nor the unannounced visits had been completed within the timelines specified in the regulations. Management informed the inspector that the annual review was due to be completed that week, however they were not aware if an unannounced visit was planned. On review of the most recent annual review action plan, it was noted that the actions were vague and most often took the form of stating there was a gap identified regarding a specific regulation with no further detail provided. Areas identified as requiring improvement included staffing, staff training, governance and management, individual assessment and plans, healthcare, and premises. There was no person assigned as responsible to address these gaps or a date by which they were to be completed. The action plan developed following the most recent unannounced visit to the centre was also incomplete. Given the findings of this inspection, it did not appear that these matters had been addressed.

As referenced earlier in this report, there was no consultation with the residents reflected in the annual report. Consultation with residents' families resulted in both positive feedback and areas for service improvement. Many relatives reported high

levels of satisfaction with the service provided, staff attitude, communication and the choice afforded to their relatives. Staff were described as respectful, approachable, helpful and by one person as 'like a family member'. Comments outlining areas for improvement included references to poor communication regarding the respite service, a preference for single occupancy bedrooms, a need for greater choice in activities for residents, requests for residents to be more involved in meal preparation and gardening, requests for access to the internet and streaming services, and an inability at times for residents to engage in their preferred activities. This feedback was not reflected in the action plan. It was stated in the annual review that the person in charge at the time had actioned a number of points raised by family members although no further detail than that was provided.

Regulation 15: Staffing

An immediate action was issued to ensure that staffing was provided in line with the statement of purpose. Assessment was required to ensure that the number of staff was appropriate to the number and assessed needs of the residents living in the centre. The practice of only having one staff on duty at a time limited residents' opportunities. Evidence indicated that as a result of this staffing number, choices regarding activities were limited and on at least one occasion a resident was unable to attend an appointment.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff training records were not available on the day of the inspection for the relief staff working in the centre. The four permanent staff working in the centre required mandatory training in fire safety, safeguarding, the safe administration of medication and epilepsy management. Staff supervision sessions were not provided in line with the provider's policy.

Judgment: Not compliant

Regulation 19: Directory of residents

A directory of residents had been established and maintained in the designated centre. This contained all of the required information.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre was not resourced to ensure the effective delivery of care and support. The management systems in place did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. There was evidence of poor oversight of many aspects of the service provided to residents, including but not limited to staffing, protection, training, complaints, and notification of incidents. The annual review, although planned, and the six-monthly visits to monitor the safety and quality of care and support provided in the centre had not been completed in line with the timeframes specified in this regulation. The annual review did not provide for consultation with residents living in the centre, as required. The feedback from residents' relatives was not incorporated into the action plan. The action plans developed as a result of the annual review and unannounced visits were vague and did not identify a person responsible or a timeframe to complete the identified actions.There was no evidence that these had been completed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had not been reviewed in the last 12 months. Not all of the information outlined in this document was accurate or reflective of the service being provided in the designated centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all adverse incidents, as specified in this regulation, that occurred in this centre were reported to the chief inspector. Not all adverse incidents that were notified were notified within the required three working day timeframe.

Judgment: Not compliant

Regulation 34: Complaints procedure

The practice regarding complaints was inconsistent in the centre. Management had not followed the provider's own policy in response to a number of complaints. As a result these complaints were unresolved and complainants were not satisfied.

Judgment: Not compliant

Quality and safety

Once this was changed to a risk-based inspection, it was also decided to focus on the regulations associated with capacity and capability. However in the course of this inspection, elements relating to quality and safety were also assessed. A review of incident records indicated that the oversight of incidents and the implementation of safeguarding and protection policies required improvement to ensure residents' safety. As was outlined in the opening section of this report, residents reported that they were happy living in this centre. It was clear that they enjoyed participating in a variety of activities and were encouraged to exercise their rights. However, it was not always evident that residents' choices and rights were facilitated in the centre.

Two incidents recorded in the centre in June and July 2021 involved allegations of abuse made by two different residents against staff members. It was not documented if the provider's and the national safeguarding policies had been implemented. These were separate incidents to the one referenced in the first section of this report whereby an incident had been referred for preliminary screening and there had been no follow up two weeks later. Given the inconsistent implementation of safeguarding policies, the poor oversight of such matters, and the need for three of the four permanent staff to attend safeguarding training, the inspector was not assured that the provider had sufficient oversight and systems in place to protect residents from all forms of abuse.

Staff explained to the inspector how they encouraged and facilitated residents to advocate for themselves and their rights. Resident meetings were called advocacy meetings and following five months where none were held, at the time of this inspection they had been occurring regularly for the previous three months. The minutes of these meetings were reviewed. Residents discussed previous, planned and requested outings, household maintenance issues and topics including safeguarding and complaints. The activities discussed were mainly community based outings and trips. These included visits to local parks and visitor attractions, as well as holidays in Ireland and a wish to go to Portugal. The inspector also saw records of in-house activities that included art, baking, beauty treatments, knitting, puzzles and movie nights.

Matters raised in residents' meetings also included one resident's preference not to return to a fulltime day service, another resident's request for new paint and curtains in their bedroom, and all residents' wish for the centre to have its own

means of transport. At the time of this inspection all of these were ongoing issues for residents with no clear plan as to how they would be addressed. In the course of this inspection the provider had decided that all four residents would attend day services four days a week, knowing that this was not in line with their wishes.

Residents told inspectors that they could receive visitors in their home. During the inspection, one relative called to the house to drop something in and see their family member. This visit had not been planned. Unfortunately, due to staffing issues on the day, the resident was not there to meet with them. The inspector reviewed documents which showed that all four residents had spent time visiting their family homes in recent months.

Areas for improvement regarding the premises had been identified in the last HIQA inspection of this centre completed in March 2020. There had been no works completed in this time so these issues remained outstanding. Residents had spoken with the inspector about recent home improvements which included painting and fitting new flooring in the living room and buying new living room and garden furniture.

The inspector also reviewed the risk register for the centre. The majority of risks included in this register appeared generic in nature and did not reflect the residents living there or other factors specific to this centre, for example, the likelihood of a loss of heating in the centre was rated as rare, despite four such events occurring in April 2021. Not all hazards had been identified as such and therefore had not been assessed. It was also noted that the risk assessments had not been reviewed in line with the timeframes specified on each document. In line with findings regarding governance in this centre, a risk regarding effective governance had been added to the centre's risk register in March 2021. This described the risk as the inability to fulfil the roles and responsibilities of the person in charge so as to meet the residents' needs and the requirements of the regulations and standards. This was rated as high risk and it was unclear what, if any, additional control measures had been implemented since March 2021 to reduce the risk.

Regulation 11: Visits

Residents were facilitated to receive visitors in accordance with their wishes.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access to opportunities to participate in activities in accordance with their interests both in the centre and in the wider community. They spoke with the inspector about things they enjoyed doing, places they had been recently and

upcoming trips they were looking forward to, including a visit to Christmas markets in a neighbouring county. The impact of staffing levels in the centre on residents' opportunity to go out alone or in smaller groups, or to remain in the centre, are reflected in Regulation 9: Residents' rights.

Judgment: Compliant

Regulation 17: Premises

As was identified in last HIQA inspection of this centre, the registered provider had not made provision for the matters set out in Schedule 6 of the regulations. This included the provision of private accommodation and baths, showers and toilets of a sufficient number.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk assessments required review to ensure they were specific to this centre, regularly reviewed, and reflective of the current hazards and the risks they posed.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding policies were not consistently implemented in the centre. When implemented, it was not done within the timeframes specified in the policy. It was not documented that every allegation of abuse was investigated.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' advocacy meetings had not been held for a continuous five month period this year. Although acknowledged, residents' expressed wishes not to return to day services on a full-time basis were not respected. Residents' opportunities to exercise choice and control regarding activities in their daily lives were limited by the

resources allocated to the designated centre.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City South 4 OSV-0003296

Inspection ID: MON-0034740

Date of inspection: 01/11/2021

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing has been assessed, a staff member who had previously worked in the house with residents has agreed to work 39hrs per fortnight across 7 days being flexible with how these hours are worked to facilitate residents' choices regarding activities	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A robust training plan has been put in place with oversight from PIC and PPIM, all mandatory training will be completed. Cope Foundation took the decision to cancel all training on 17/11/2021 until January 2022 to reduce unnecessary contact across services so as to maintain safety of people supported by Cope Foundation. Staff from CCS4 have been booked to complete training once mandatory training is re-introduced	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
The management systems in place have been reviewed. The PIC will ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. The PIC will provide oversight to ensure that all aspects of the service provided to residents, including but not limited to staffing, protection, training, complaints, and notification of incidents will be monitored. The annual review was carried out by the PPIM as scheduled, a schedule for six-monthly visits to monitor the safety and quality of care and support provided in the centre have been booked for 2022. Residents satisfaction surveys have been given to all residents, these will be forwarded to the auditing team, feedback from residents and families will be incorporated into six-monthly visit action plan. The action plans developed as a result of annual review and unannounced visits going forward will be overseen and actioned by the PIC and PPIM.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of purpose has been reviewed by the PIC to reflect the service being provided in the designated centre.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Going forward the PIC will ensure that all Notifications of incidents are dealt with in accordance with the regulations.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Going forward the PIC will ensure that all complaints are dealt with in accordance with the registered providers complaints policy. All complaints had been reviewed and closed out in a timely manner to the satisfaction of the complainant

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Facilities manager and OT completed a survey to establish a plan to ensure the provision of private accommodation and baths, showers and toilets of a sufficient number. Further discussion to take place with the provider in relation to the proposed plan following the survey.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The risk register is currently being updated by the PIC to reflect ongoing risk in relation to current hazards and the risks that they posed.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The PIC and PPIM will ensure that all safeguarding policies will be consistently implemented in the centre going forward, ensuring that when implemented, these are done within the timeframes specified in the policy. The PPIM has reviewed documentation around previous allegations of abuse. These are being investigated retrospectively	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights:	

The PIC has met with all residents individually and as part of the house group. The PIC will attend residents' advocacy meetings on a bi-monthly basis commencing in January 2022. Minutes of all advocacy meetings will be signed by the PIC to ensure the adherence of monthly meetings. Residents' expressed wishes not to return to day services on a full-time basis were discussed when PIC met with the house group, all residents expressed the wish to return to day services. A staff member who had previously worked in the house with residents has agreed to work 39hrs per fortnight across 7 days being flexible with how these hours are worked to facilitate residents' choices and control regarding activities in their daily lives

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.	Not Compliant	Orange	06/12/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	06/12/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Not Compliant	Orange	31/01/2022

	as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	06/12/2021
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	14/01/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	06/12/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	06/12/2021

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	06/12/2021
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.	Not Compliant	Orange	31/01/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Substantially Compliant	Yellow	31/12/2021

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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	06/12/2021
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Not Compliant	Yellow	10/12/2022
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	06/11/2021
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	06/12/2021
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is	Not Compliant	Orange	06/12/2021

	informed promptly of the outcome of his or her complaint and details of the appeals process.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	06/12/2021
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	06/12/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	06/12/2021
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.	Not Compliant	Orange	10/12/2021
Regulation 08(7)	The person in	Not Compliant	Orange	06/12/2021

	charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	06/12/2021