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 7
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	10 February 2021
Centre ID:	OSV-0003297
Fieldwork ID:	MON-0031052

About the designated centre

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

Cork City North 7 is comprised of four houses on a campus setting in Cork city. There are other designated centres on this campus. The centre provides a residential service to 29 people, who live in the centre on a full-time basis. The centre provides services to both males and females, over the age of 18 years.

Each house is a two-storey building with the same layout. This includes a kitchen, separate dining room, sitting room and sun room. Each house has both downstairs and upstairs bedrooms. Some residents in each house share their bedrooms with others. The centre is staffed at all times. The staff team consists of a social care worker, care assistants and nurses.

The stated aim and objective of the centre, as outlined in the statement of purpose, is to promote a welcoming and homelike environment ensuring always that residents' dignity and safety is promoted.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	28

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 10 February 2021	10:00hrs to 14:45hrs	Lisa Redmond	Lead
Wednesday 10 February 2021	10:00hrs to 16:30hrs	Elaine McKeown	Support

What residents told us and what inspectors observed

From what residents told us and inspectors observed, the lived experiences of residents living in the designated centre were very different. It was evident that while residents in some areas of the designated centre enjoyed a good quality service, improvements were required to ensure that other residents were appropriately supported, and that their rights were promoted and protected.

The inspectors visited two of the four houses in the designated centre. One inspector met with eight residents living in one house, while the other inspector met seven residents living in the second house. The inspectors also spoke with five residents' family members, who expressed their views on the quality of care their loved ones received.

Both houses were warm and clean. In the first house there was framed artwork and stencils decorating the walls. There were also framed photographs of the residents in the sitting room which showed the residents enjoying many different activities outdoors. Staff in this house spoke of how the residents enjoyed spending time in the sensory room which had privacy screens applied to the windows and new blinds had been ordered to enhance the atmosphere within the room. At the time the inspector visited the house, a film with lots of music was being projected onto the wall in this room.

The inspector met with all eight residents who lived in this house, and they were being supported by staff in the sitting room area when the inspector arrived. The inspector was informed that residents had their own preferred seating and staff outlined how one resident liked to sit in their own chair near a radiator in the room. This resident had sustained a few bruises in recent months which were consistent with accidentally hitting the radiator. Staff explained that they were awaiting delivery of corner protectors to reduce the risk of further injury to the resident, as the resident had indicated to staff they did not want to move their chair from the location.

The inspector was informed that some of the residents had participated in baking earlier in the day and all had enjoyed tasting the end result at lunch time. In addition, staff spoke of how one resident had been supported to personalise their bedroom in recent months. The inspector was able to see a sensory board the resident had made with staff support that was hanging on their bedroom wall. Staff explained that the resident removed and replaced items on the board regularly as per their choice.

The residents had access to a secure garden area to the rear of the house which included a water feature and seating areas. However, there was a broken frame from a garden seat that was standing on edge in one area of the garden. The inspector observed one leg of the frame sticking out at a high level which could have caused injury to those using the garden area. The person participating in

management contacted the maintenance department to organise for the immediate removal of the frame on the day of the inspection.

Staff were very familiar with the communication needs of the residents in the house. Staff spoke of how one resident was progressing well using sign language, as their responses to staff occurred more frequently in recent months. The inspector observed staff responding to one resident requesting a hot drink. When other residents heard the kettle boiling they came into the kitchen area and were also offered their preferred hot drinks.

The inspector was invited to see a number of residents' bedrooms when they visited the second house. It was evident that they had all been decorated in line with the individual likes of each resident. The garden area had been enhanced and re-developed following a resident's request for this to be completed, through the organisation's complaints process. The person in charge told the inspector that the garden was enclosed, so that residents could access it safely.

Residents living in the second house were non-verbal communicators, and used physical gestures, facial expressions and vocalisations to communicate their needs to staff members. Therefore, none of these residents were able to tell the inspector their views on the quality and safety of the service. Residents were observed to be mobilising in the house, following the activity of staff members and the inspector as they walked around. It was noted that the second house was very noisy, due to a number of resident's vocalising loudly at the time of the inspection. One resident's facial expressions communicated that they were not happy with one particular resident who was vocalising loudly. The inspector observed this resident attempt to hit the resident who was vocalising. This was not witnessed by either of the two staff on duty at the time of the inspector's visit, or the person in charge.

It was evident that this house was extremely busy, and that it would be difficult for staff members to provide support to all of the residents that lived there. At times of reduced support, residents in the four houses were subject to a restrictive practice. The restrictive practice was a lock to the kitchen door, restricting residents' access to the kitchen area. In the first house, the inspector spoke to staff about this restrictive practice. Staff spoken with told the inspector that the restrictive practice was implemented when there were only two staff members in the house. The kitchen door was locked when one staff was preparing meals and the other staff supported the residents in the house. The inspector was informed that this restriction was not used when there were three staff on duty during the day. At the time of the inspector's visit to the second house, the kitchen area was locked. The rationale for the restrictive practice being in place was that one staff member had gone for their lunch break.

The inspector asked to see the kitchen area in the second house. When the inspector and the person in charge entered the kitchen area, two residents also entered. One resident proceeded to open the fridge and take out a yogurt, communicating that they would like to have it. A staff member told the resident to put the yogurt back into the fridge. The resident handed the yogurt to the staff member who put it back into the fridge. It was not evident why the resident was not

allowed to have the yogurt. The inspector reviewed this resident's personal plan and did not find any evidence that this resident's access to food was restricted. This issue was raised with the person in charge at the time of the inspection.

16 residents living in the designated centre shared a bedroom, with two residents in each of the eight shared bedrooms. Staff members told the inspectors that there had been no reports of residents having disturbed sleeping patterns due to sharing a bedroom. However, it was evident that there was little private space for these residents to retreat and have some time alone, if they so wished.

In the residents' files, it was noted that they had participated in a number of activities including online yoga, music, singing, walking, Zumba, online exercise classes, baking, disco, beauty treatments, such as nails and hair, massage, sensory rooms and relaxation. Staff members had also had supported residents to do an online step challenge.

The person participating in management outlined that Internet access was provided to residents through the use of the organisation’s mobile phones, which were available for use in the designated centre. Two dongles to support Internet access were also available, with two more awaiting delivery. This would further support the residents' access to the Internet.

The inspectors spoke with the family members of five of the residents who lived in the designated centre. Overall, residents' family members were happy with the supports being provided to their loved ones. Two family members noted the improvements they had seen to the service provided in the centre. Residents' family members were happy with the staff supporting their family members, telling inspectors that they are 'great', 'caring' and 'wonderful'. One family member told the inspectors that staff members had supported one resident to get a coffee machine, while staff members in another area had set up an art table for a resident who recently discovered a love of art. One resident's family did note that it would be a challenge for staff members to give one-to-one time to each resident due to the staffing levels in the designated centre.

A number of residents' family members also told the inspectors that the person in charge was accessible to them, and that they were available to support residents and their families. For example, when one resident was supported to go home on a visit, the person in charge was available to give advice to their family on how best to support them to manage behaviour that is challenging.

As part of the findings of the previous inspection of this designated centre, four residents were due to transition to a new home in the community. One resident's family members were aware of the proposed transition, and told the inspector that they were kept informed of any progress in the resident's transition. The family member also noted that they were involved in the resident's person-centred planning meetings and the goals that they developed. However, they noted that this had not occurred since the beginning of the COVID-19 pandemic.

Capacity and capability

This inspection was carried out to review how the registered provider had implemented actions to improve the quality of service provision, following the inspection completed by the Health Information and Quality Authority (HIQA) in January 2020. It was evident from the findings of this inspection that the designated centre was not resourced to ensure the effective delivery of care and support to the residents that lived there. Improvements were required to ensure that the service provided to residents was safe, appropriate to their needs and effectively monitored.

Since the inspection completed by HIQA in January 2020, a dedicated person in charge had been appointed to the designated centre. It was evident that this person had the necessary skills and qualifications to fulfil the role. A person participating in management had also been appointed to ensure effective oversight and monitoring of the designated centre. This individual reported to the general manager, who then reported directly to the chief executive officer.

It was evident that the person in charge had regularly escalated and highlighted staffing issues to the person participating in management, and other members of the senior management team. It was evident that the staffing levels in place at the time of the inspection were not appropriate to ensure that residents were provided with a good quality of service.

A business case had been put forward by the registered provider to seek funding for additional staffing, however this staffing had not been provided at the time of the inspection. An updated review of the staffing levels required in the designated centre was completed by the person in charge and the person participating in management the day before the inspection took place. It was acknowledged that these staffing levels could not be supported with the current number of staff members working in the designated centre.

It was noted that at times when staffing would allow, the person in charge attempted to roster additional staff in two of the four houses, however this was not always possible. Therefore, it was evident that the designated centre did not have adequate resources to meet the needs of the residents who lived there. Although HIQA had accepted that the provider would not be in compliance with this regulation until 31 July 2021, it was not clearly outlined how the Provider intended to come into compliance with this regulation on the date specified.

Some improvements had been made since the inspection carried out in January 2020. Respite services were no longer provided in the designated centre. Residents who lived in the designated centre had an agreement in writing which identified the service they were to be provided with in the designated centre, and the fees to be charge to provide this service. There was also evidence that residents had been supported to make complaints about the service they received, and that improvements were made based on this information.

Following a review of the designated centre's training matrix, it was noted that there were gaps in the provision of training to support residents to manage behaviour that is challenging.

Regulation 14: Persons in charge

A dedicated person in charge had been appointed in the designated centre. It was evident that this person held the necessary skills and qualifications to fulfil the role.

Judgment: Compliant

Regulation 15: Staffing

It was evident that the designated centre did not have an appropriate level of staffing to ensure that residents were provided with a good quality service. On review of the rota, the staffing levels in place were below the levels outlined as required in the review of staffing completed for the designated centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Following a review of the designated centre's training matrix, it was noted that there were gaps in the provision of training to support residents to manage behaviour that is challenging.

Judgment: Substantially compliant

Regulation 23: Governance and management

It was evident that the designated centre was not adequately resourced to ensure that the delivery of care was safe, appropriate to residents' needs and consistent and effectively monitored. Due to a lack of funding, staffing issues in the designated centre had not been rectified, with a direct impact on the quality of service provided to residents. Although HIQA had accepted that the provider would not be in compliance with this regulation until 31 July 2021, it was not clearly outlined how the provider intended to come into compliance with this regulation.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

An agreement in writing, outlining the services to be provided to residents in the designated centre, and the fees to be charged had been completed.

Judgment: Compliant

Regulation 31: Notification of incidents

Following a review of the incident log in the designated centre, the complaints log and a sample of resident's daily notes, it was evident that any adverse events occurring in the designated centre had been notified to the Chief Inspector, as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

It was evident that residents had been supported by staff members to make complaints, and that improvements to service provision were made from the complaints. For example, there was evidence that one resident had been supported to access their pension, while there was evidence of improvements to the garden area.

Judgment: Compliant

Quality and safety

It was observed that some improvements had been made to the quality of service provided to residents since the inspection carried out by HIQA in January 2020. However, significant improvements were required to ensure that residents received a good quality service, and that their rights were promoted and respected in the designated centre.

The inspectors reviewed a sample of residents' files. Of the four resident files that

were reviewed, none of these residents had a person-centred planning meeting in 2020. Improvements were also required to ensure residents' goals were reviewed or readjusted to reflect the COVID-19 restrictions. For example, one resident had a goal to join a community gardening activity. Although this could not be achieved due to COVID-19, there was no alternative goal identified for the resident in that could be achieved in the designated centre, in line with their interest in gardening.

A plan was in place to move the residents that lived in this designated centre from the campus-based accommodation, to homes within their local community. At the time of the inspection, the registered provider was trying to locate a suitable premises for four residents to transition together. Residents' representatives had been informed of the proposed transition. It was noted that these residents had not been informed that they would be transitioning to a new home, however, the rationale for this was the uncertainty regarding the location of the transition, and the impact this may have on the residents.

A number of residents had a positive behaviour support plan, to support them to manage behavior that challenges. Psychology and multidisciplinary input was available to these residents however, it was noted that recommendations following these reviews were not always implemented in a timely manner. For example, a recommendation to enhance one resident's independence of choosing their own music by using a push button device had not been completed at the time of the inspection one year later.

Each resident had a personal evacuation plan in the event of a fire, which reflected their support needs on evacuation of the centre. At night time, it was noted that staff members from different areas would be alerted to assist in the evacuation of residents. The person in charge told inspectors these staff members were aware of the personal evacuation plans in the houses that they would need to support, in the event of a fire at night. It was noted that when fire drills were carried out, they did not always document how long it had taken for residents to be safely evacuated. Improvements were also required to the management of daily checks on escape routes, to ensure they were carried out as per the registered provider's guidance.

A number of measures had been put in place to protect residents from potential sources of infection, including COVID-19. Staff working in the centre wore personal protective equipment (PPE) while on duty. It was noted that there was no appropriate waste disposal for staff members to dispose of used PPE as they exited the designated centre. It was also observed that cleaning was not always documented as having taken place in the cleaning schedules reviewed by inspectors in the centre.

Residents had been supported to receive visitors, and go on home visits in line with COVID-19 guidance. A visitor's room had been made available to residents, to provide a private area to receive a visitor.

Regulation 10: Communication

Residents had been provided with access to appropriate media, including access to the Internet. Internet access was provided to residents through the use of the organisation's mobile phones. Two dongles to support internet access were also available, with two more awaiting delivery.

Judgment: Compliant

Regulation 11: Visits

Residents were supported to receive visitors in line with COVID-19 guidance on visiting. As an action from the inspection carried out by HIQA in January 2020, suitable private visiting area had been made available to residents to receive a visitor.

Judgment: Compliant

Regulation 17: Premises

It was evident that there was insufficient private space for residents to retreat for some quiet time, if they so wished. 16 residents shared a bedroom, and it was observed that some areas of the designated centre were busy and noisy at times, with lots of people present in communal areas.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

It was evident that there were systems in place for the ongoing assessment and management of risk. The person in charge had completed a full review of all risks in the designated centre in October 2020. Where there were high-level risk issues, including staffing, there was evidence that the person in charge had regularly raised these issues with senior management.

Judgment: Compliant

Regulation 27: Protection against infection

Improvements were required to ensure that residents were protected from infection. There was no appropriate area for the disposal of used PPE when staff members were leaving the designated centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvements were required to the management of daily checks on escape routes, to ensure they were carried out as per the registered provider's guidance. It was not always documented how long it took for residents to evacuate the designated centre when a fire drill was conducted.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Improvements were required to ensure that residents' personal plans were reviewed with the involvement of the resident and their representatives, where appropriate. Of the four resident files that were reviewed, none of these residents had a person centred-planning meeting in 2020. Improvements were also required to ensure residents' goals were reviewed or readjusted to reflect the COVID-19 restrictions.

Judgment: Substantially compliant

Regulation 6: Health care

It was evident that residents were provided with appropriate access to healthcare and allied health professional in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors reviewed a number of residents' positive behaviour support plans. It was noted that recommendations following a review of one resident's behaviour support plan had not been implemented in a timely manner.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had systems in place to ensure that residents were protected from abuse. At the time of the inspection, there were no open safeguarding plans in place in the designated centre.

Judgment: Compliant

Regulation 9: Residents' rights

It was evident that residents' access to the kitchen area was restricted at times of reduced staffing. It was also observed that one resident was not given the freedom to exercise control and choice in regards to having a yogurt.

There was a lack of private areas for residents to seek privacy and time alone, if they so wished.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City North 7 OSV-0003297

Inspection ID: MON-0031052

Date of inspection: 10/02/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Since inspection, the PIC, PPIM and ADON in Allocations have met to review the staffing levels, skill mix and rosters within the centre. (22/3/21) The following points of action were agreed: • It was agreed that three staff would be recruited permanently to bring the staffing back up to the agreed, necessary allocation to meet the needs of the residents. • As an interim measure, these positions are filled by relief and agency staff to ensure residents' rights are met and to deliver on a good quality of life for all of the individuals supported in CCN7. • The recruitment for the three staff will be completed by 31st May 2021. • Meetings will be held between the PIC/PPIM and ADON Allocations quarterly in 2021(or more often if required) to ensure that known upcoming vacancies can be planned for. The meetings will also focus on effective rostering, holiday allocation and skill mix as the needs of the residents change over time.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC has a training matrix in place for all staff training and will schedule training	

accordingly to ensure all staff have the necessary skills to support the residents.

• The training matrix will be discussed at the PIC/PPIM's 1:1 meetings to ensure that the provider is meeting its obligations in the provision of mandatory and other training.

• Positive behavior support training has been scheduled for March 23rd, March 30th, April 8th, April 15th and May 6th 2021. All staff in this designated centre will have positive behavior support training completed by 6/5/2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PIC / PPIM and ADON in Allocations will meet quarterly to review staffing in the designated centre. This meeting will focus on effective and efficient staff rostering, appropriate skill mix within the residences, applying the annual leave policy appropriately and to plan for any known up-coming vacancies. An action plan will be developed after each meeting with clear timelines and deliverables. This will ensure oversight by the provider around staffing within the centre in delivering on safe, effective high-quality services and supports for people.

• On 31st May when the newly recruited staff are in position, one person will be identified as the second "activities, goals and recreation" staff within the designated centre. This person will have a clear remit and role in the provision of individualized supports to residents based identified PCP goals and support needs.

• A CNM 1 position was advertised in March 2021. There was no successful applicant. The position was advertised again externally on the 23/3/2021.
To be completed by 14/5/2021.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• It is recognized that residents need more private, quiet time within their home. It is also recognized that residents need support in accessing suitable activities and recreational opportunities to meet their needs and improve their quality of life. Residents

have access to an activity/recreation room and a multi-sensory room on the campus outside of the residence. The PIC and the team of staff will carefully schedule activities and recreation in these resource rooms away from the residence to enable the other residents to have privacy and quiet time in a quieter environment within their home. This schedule will be completed by 31st March and will have due cognizance of each residents' preferences based on their PCP goals and /or support plan.
• The provider's plan for four people to move from the designated centre to a residence in the community was delayed due to COVID-19 restrictions and the lack of suitable property available in 2020/2021. The provider has identified a suitable property in Ballincollig which will be available for occupation at the end of quarter 1 in 2022. A deposit has been paid to secure this property and the provider is satisfied that it will meet the needs of the residents based on individual assessment.
• A carefully managed transition plan will be put in place in quarter three and four of 2021 to support residents in moving out of a large congregated setting and into a home of their own. The organisation has employed a community transition coordinator to support this process and work alongside the PIC and team in ensuring a rights-based approach is taken. Appropriate processes and documentation such as the HSE's "Making Homes" and the "Community Transition Toolkit" will be utilised in ensuring a successful person centred transition for the residents.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• All staff have completed mandatory training with regard to COVID- 19 in ensuring we meet our infection prevention and control standards.

• Each residence has a designated bin at the back door. On date of inspection one bin was not in place. The PIC has since put a bin at back door as staff enter and exit residence for the purpose of changing clothes as an IPC measure. Masks / PPE equipment have a designated bin in place for disposal as appropriate. Date of completion 11/2/2021.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC has included an additional daily process to the daily checks log. All escape routes are walked through and checked by the designated staff on a daily basis. The

egress route from the upstairs bedrooms will also now be included; it leads to exit steps. Date of completion 31st March 2021.
• The PIC has put a process in place that the designated person will make a note of the time it took for completion of the fire drill and record this information in the fire book. The PIC has put a notice by the fire box storage and informed all staff of this process.
• A staff member has been assigned to complete a monthly an audit of the fire books. Date of completion 11/2/2021.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The PIC has completed a schedule of personal plans for review annually or more frequently if there is a change in needs or circumstances. This schedule will be reviewed at the monthly 1:1 meetings with the PIC and the PPIM to ensure the provider is meeting its obligations and that all residents have an up to date support and personal plan.
• Since inspection, the PIC and team of staff have completed nine PCPS. All PCPS will be completed by 31/5/2021.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The PIC submitted a referral in June 2020 and a button for individual choice of music was requested. At the time of referral this priority was returned as priority 2, with a wait of 8 months identified. The PPIM will ensure that this referral is re-prioritised and will attend the next adult services support meeting to discuss same.
• The PIC is currently establishing a matrix for CASS referrals to ensure oversight around referral times and communication with the multidisciplinary team. The matrix will be completed by 31/3/2021. This can be discussed at the monthly 1:1 with the PIC/PPIM. The PPIM can bring forward any concerns with waiting times to the CASS meeting as appropriate.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC will review the policy around rights restrictions with all staff. (Completion April 2021)
• The provider will ensure a rights-based culture which supports residents to have choice and control over their own lives. The PIC will ensure that residents have choice over both small and large issues which affect them.
• Training on the Assisted Decision Making and Capacity Legislation(2015) was provided to all managers on 22/3/21. The presentation, relevant documentation and resources on building people's capacity to make choices and decisions will be provided to managers by 26/3/22. The PIC will provide this information to the team in CCN7 by 20/4/2021.
• All staff will attend training around rights-based practice by May 30th 2021. This training will be provided by the rights oversight forum.
• The provider is commencing a rights and equality staff campaign on 24/3/21. This campaign will engage with staff on how to take an equality and human rights-based approach in supporting people.
• The PIC will review the restrictive practice log in the designated centre by 7/4/21 to ensure that restrictions are eliminated where possible and all restrictions are monitored and reviewed on a regular basis.
• The PIC and PPIM will discuss rights-based cultures, restrictive free environments, the promotion of choice, control and dignity at the regular 1:1s.

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	31/05/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	06/05/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/03/2022

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	31/05/2021
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	31/05/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	10/02/2021
Regulation 28(1)	The registered provider shall ensure that	Substantially Compliant	Yellow	11/02/2021

	effective fire safety management systems are in place.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	31/05/2021
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/05/2021
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is	Substantially Compliant	Yellow	31/05/2021

	the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	24/05/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/05/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or	Not Compliant	Orange	30/05/2021

	her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			