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 24
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	16 December 2021
Centre ID:	OSV-0005623
Fieldwork ID:	MON-0032267

About the designated centre

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

The centre is a congregated setting on the northside of a large city. The centre comprises of three buildings - a main building of two floors and two individual attached houses. The houses are adjacent to the main building. The designated centre provides residential care services for adult female residents who have a mild or moderate intellectual disability. On the date of inspection there were 22 residents living in the centre and it was closed to further admissions. Many of these residents had been living in the centre for a significant period of time. Residents ranged in age between 24 and 82 years of age, requiring minimum to medium support. The service is led by nursing staff and social care staff supported by healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	22

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
Thursday 16 December 2021	10:00hrs to 18:30hrs	Michael O'Sullivan	Lead
Thursday 16 December 2021	10:00hrs to 18:30hrs	Lucia Power	Support

What residents told us and what inspectors observed

Prior to 2017, this designated centre was run by St. Vincents Centre and in March 2017, the Health Service Executive HSE, in accordance with Section 64(4) of the Health Act 2007 took over the operation of the designated centre, as the registered provider, until such time as an alternative provider was sourced. The current registered provider Cope Foundation undertook this role in their own right from March 2021. The current provider had a plan to transition residents to smaller community based housing by 2023, when the current premises were due to be vacated and returned to the landlord.

Many residents had lived in the centre or an associated institution for many years, some being admitted at a young age due to life events. Life had been extremely difficult for a number of residents.

The inspectors met and spoke with 15 residents during the course of the inspection. Residents were met individually and in small groups. Social distancing was maintained and both inspectors wore face masks and undertook standard infection prevention precautions. Most of the residents were able to tell the inspectors their views and when afforded time were open and articulate with the inspectors.

Overall, inspectors found that residents were well cared for and supported by staff, and had a pleasant living environment. However, many residents expressed distress and upset at the changes that were happening and how the HSE and the provider were managing these changes.

The general welfare, care and support given to residents was very good and records evidenced a timely response to healthcare matters and professional referrals were addressed as a matter of priority. Residents did not have to wait long to be assessed by clinicians employed by the registered provider and general practitioners were those of the residents choosing.

Residents knew many of the staff by name and while there were high levels of agency staff employed, the same staff were consistent over a number of years. One resident was busy knitting a festive scarf for their keyworker. This resident said that sometimes residents could be noisy and at times they wished for a quieter environment.

Many residents spoke to inspectors regarding the unexpected and sudden recent death of a member of staff. Residents said that this staff member knew everything about them and was always there for them. The loss was one that had impacted greatly on the residents and the staff team alike.

Inspectors observed staff being very gentle and respectful with residents and interactions also displayed the regard that residents had for staff. For example, a resident was observed linking arms and walking with their keyworker to a local

shop. While this was subsequently noted in the residents care plan as a goal that the resident and their keyworker had set, it was also apparent that the relationship between the two people was based on mutual respect and trust.

However, some residents expressed concerns about how their personal finances were being managed. They told inspectors that they were aware that there had been issues in relation to their personal finances in years gone by and that these had been subject to a review and that monies had now been deposited in their accounts. However, residents stated that they were unhappy because they had not been told about the outcome of the review or whether the matter had been concluded.

Residents told inspectors that the HSE and the new provider had discussed moving to new homes with them, but this had not been progressed because of the pandemic. Two residents had moved out of the centre and other residents told inspectors that the provider had put arrangements in place so that they could stay in contact with them. Another resident told inspectors that they were planning to move shortly.

However, other residents were aware that they had to move from their current home by 2023 and were very anxious about the way this would be done. They told inspectors that they had stopped going to meetings because the provider was not giving them updates or any new information. For example, some residents spoke about being brought to see a new house and being told about upgrades and renovations that would be completed before they moved in. However, they said that this had been almost two years previously and that they had not been given any updates on when they would move to their new house. Residents were visibly upset when telling the inspectors about these concerns.

Residents told inspectors that they had met with managers from the HSE and from the current provider before COPE Foundation was registered as provider for the centre. They said they were told that while they were waiting for their new homes, nothing would change in their current centre. Residents told inspectors that they had now been told that they would have to pay significantly increased rent to the new provider which would leave very little from their disability allowance for personal spending each week. Residents said that they were very upset at these changes.

Residents described the independent advocacy service that the provider had put in place. They confirmed that they had opportunities to meet on an individual basis and in groups with the advocates. The residents stated that they did make complaints through the advocates about a number of issues including the delays in moving to new accommodation and the significant increase in charges for residents. Inspectors saw records of these issues being brought to the attention of the provider but there was no evidence of a provider response, and residents told inspectors that they were frustrated with the advocacy arrangements because of the lack of response.

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 inspectors reviewed the terms of reference for a transition planning group that had been set up to oversee the transition of services from the HSE to the current registered provider. This group was comprised of nine senior managers from both organisations. The role of the group was to provide strategic direction and leadership to ensure and facilitate a seamless transfer of services from one registered provider to another. The terms of reference determined that the group would be effective for 6 months from the 01st of September 2020 and that it would be necessary to review and repurpose the function of the group following transition, given the importance of ensuring decongregation. There was no evidence that this had occurred or that any of the parties had sought to convene a meeting since registration.

Since the previous inspection, a new registered provider had taken on the responsibility of the designated centre. The governance and management structures had significant changes impacting on the effectiveness and leadership of services overall. While the care provided to residents was good, the support given to residents for areas of importance to them and voiced by them, had not been met. While the registered provider was collecting information to improve and sustain a quality service, there was little evidence that the information, especially residents views, were used to inform such change. There was a deterioration in the level of regulatory compliance in relation to regulations that had been compliant on previous inspections.

The inspectors noted that the provider had not implemented the management structure set out in the statement of purpose when they took responsibility for the centre, which had resulted in a significant increase of administrative work for the person in charge. The statement of purpose submitted as part of the registration process, had a director of services and a general manager role that had direct responsibility for human resources, oversight of residents financial accounts, administration services, maintenance services, laundry services and catering services. Both of these posts no longer existed and while a regional manager had recently been appointed and the statement of purpose has been amended to reflect the new arrangements, inspectors found that there was insufficient support for the person in charge and they had a significantly increased level of responsibility.

Additionally, the immediate staff supports reporting to the person in charge had been on extended leave. Staff numbers and rosters had been maintained to a sufficient level, however the registered provider was filling social care worker posts with healthcare assistant posts, which was a departure from the staffing structure in

the statement of purpose. The person in charge was planning to retire in the coming months and there was no evidence that a succession plan was in place.

Inspectors found that the provider was failing to consult adequately with residents. The six monthly audits and annual review of the services did not include the input or voice of residents, which is required by regulations, despite many records reflecting the issues that were causing most concern for residents. Residents had expressed concerns in relation to their accommodation and their personal finances and these were not being reflected.

The registered provider had in place a current policy for complaints. Complaints were not being dealt with in accordance with the registered providers policy. The complaints officer was not making a determination in relation to issues raised as all resident concerns were lodged with the contracted advocacy service. While records reflected that advocacy services met with and supported residents through individual and group forums, issues reported to senior management had not been responded to.

The provider's written policies and procedures were reviewed on the day of inspection. A number of these policies required review and exceeded the three years review period as cited in the regulations, or exceed the providers own identified timelines. For example, given the historical issues relating to residents' personal funds and the current issues, it was noted that this policy had not been updated. Overall, twelve polices as outlined under schedule 5 required review and updating in accordance with best practice.

Covid-19 and the pandemic had impacted on face to face training within the designated centre. Fire and safety refresher training was required by staff. The person in charge informed the inspectors that all staff were scheduled to partake in such training in January and February 2022.

The registered provider is to inform the Chief Inspector of alleged incidents of abuse within the required three day time frame. Some areas of concern that were recorded in advocacy notes had not been investigated, nor were they reported to the Health Information and Quality Authority (HIQA).

New contracts for each resident were supposed to be signed by residents by January 2021 according to the statement of purpose. At the time of inspection, contracts had not been given to residents as the increase in residential charges had yet to be explained to residents by senior management. While charges had been legitimately calculated by the registered provider, the significant increase in cost to residents was a departure from commitments to them that services would not significantly change. There was no evidence available on the day of inspection that residents had been consulted with prior to these charges been reviewed.

The statement of purpose was subject to regular review by the person in charge. A copy of the statement of purpose was available in the reception area. This area also had the certificate of registration displayed in a prominent place.

Regulation 15: Staffing

The registered provider had in place the number of staff appropriate to the assessed needs of some residents, however, the qualifications and skill mix of staff were not consistent with the statement of purpose.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge ensured that staff had access to refresher training. While a large number of staff required training in relation to fire and safety, the person in charge demonstrated that training had been booked and scheduled to take place in January and February 2022.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that systems were in place that were appropriate to residents needs and concerns, nor were these systems effectively monitored. The staffing structure and team composition were not in accordance with the registered providers statement of purpose. There was an overall lack of senior management oversight. The registered provider is required to ensure that the annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards. The annual review of the safety and quality of the service did not include the views of residents, their representatives or advocates.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had a new contract of service provision available to residents, however, the terms and conditions of residency had not been discussed or agreed with residents or the residents representatives. There was a planned significant increase to the fees charged to residents despite previous assurances that there would be no changes and this had not been discussed with residents by

senior management. There was no evidence available on the day of inspection that residents had been consulted with prior to these charges been reviewed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had in place a current statement of purpose that clearly outlined all Schedule 1 information as required. The statement was subject to annual review and a copy was available in the reception area to residents and visitors.

Judgment: Compliant

Regulation 31: Notification of incidents

Two incidences of alleged abuse of residents had been noted by the residents advocacy services. Neither issue had been addressed or dealt with. No report had been made to HIQA.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider did not have an effective complaints procedure in place in the designated centre. Some complaints had not been dealt with effectively. Complaints were not subject to prompt investigation. Residents were not informed of the outcome of complaints. Improvements were not put in place. The nominated person - the designated officer, was not dealing with complaints directly. All complaints were reported to an advocacy service. This was a departure from the registered providers complaints policy where the role of advocacy was to support a resident make a complaint.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had not ensured that policies and procedures were updated

at intervals not exceeding three years.

Judgment: Not compliant

Quality and safety

Inspectors found that direct care and healthcare being provided by staff was of good quality, however the current living arrangements were not satisfactory to residents and there was distress demonstrated by the residents on the day of inspection, due to the lack of movement into community houses, which a number of residents articulated was having an adverse effect on their overall well-being. This inspection found an increase in areas of non compliance since the last inspection which was previously carried out in July 2019.

Of particular concern were reports reviewed by the inspectors on the day of inspection, of alleged abuses that were not perceived as abuse by either the advocacy service that noted them, or the registered provider that they were reported to. As a consequence, these matters were not the subject of investigation, nor were they reported to HIQA.

Residents were observed to be upset and fearful regarding their future and residents clearly explained to the inspectors the frustrations they encountered when trying to seek answers or receive updates relating to their accommodation and financial concerns. Some residents stated that they had no or little control over their own life.

Resident's were supported and assisted to maintain their own living areas, bedroom, bathroom and kitchen dining areas. Residents were also supported to do their own laundry. There was sufficient room for residents to store personal property, possessions and items of interest.

The houses contained individual fire alarm systems. All fire exits on the day of inspection were observed to be clear. Staff recorded daily fire checks and fire drills demonstrated that all residents could be safely evacuated. All rooms and corridors had emergency lighting with the exception of one corridor that had been identified previously on inspection in 2019. All fire prevention and detection systems had been serviced by a fire competent person in 2021. Fire extinguishers had been serviced and fire blankets were present in kitchen areas.

Resident's had defined goals that were subject to review by a designated key worker. The annual review of individual plans incorporated the input from the resident, their key worker, families and the multidisciplinary team. All personal care planning documentation was accessible and maintained in good order. A number of residents files were reviewed by the inspector. Goals were agreed with the residents, however, some goals had not been achieved due to the pandemic but the effectiveness of the plans were reviewed. Each resident had a current plan and information in relation to their healthcare needs. Plans were comprehensive.

Changes noted in relation to residents health were supported by relevant follow up and appropriate requests for assessments and appointments. Positive behaviour support plans were supported by current psychological reviews. For example, one resident's file reflected that the resident had difficulties during lockdown and that they were supported with cognitive behavioural therapy (CBT). Once restrictions were lifted, this resident determined that they were no longer in need of CBT.

Restrictive practices were noted to be subject to review by the registered providers restrictive practices committee and were for the least restrictive measure. Restrictive practices in place on the day of inspection had all been previously advised to the HIQA. Practices were of the least restrictive means to ensure resident safety and all were individually risk assessed. There was a current and up-to-date risk register in the designated centre. All risks were particular to the service and the residents.

The risk of COVID-19 and its impact on the residents was clearly documented. The registered provider had easy to read documents to explain COVID-19 to residents. Staff had facilitated family visits to the designated centre, however, resident's were starting to resume home visits and stays at the time of inspection.

All three houses were observed to be clean. Staff had organised cleaning schedules to include the increased rate of cleaning of frequently touched areas. Staff had undertaken training in infection prevention controls, as well as hand hygiene. Staff practices and the use of PPE on the day of inspection was noted to be good. Staff supported and reminded residents of the risk of infection. All residents touched elbows with the inspector and were aware not to shake hands. The registered provider had a contingency plan in place to address the possibility of an outbreak of COVID-19. The registered provider had a staff contingency plan in place. One staff member was identifiable as the registered providers nominated lead worker representative. Current advice from the Health Protection and Surveillance Centre including variants of concern, was available on site. The recording of staff, residents and visitors temperatures was adhered to by all staff. Staff used an independent entrance when attending work.

The age of the premises resulted in a deterioration of wall, floor, ceiling and general surfaces that made the cleaning and sterilisation of surfaces difficult. While ongoing maintenance was occurring, the fabric of the premises impeded achieving the standards for the prevention and control of healthcare associated infections.

Resident's were been supported to communicate in accordance with the residents' needs and wishes. Some residents used mobile phones and had access to the internet and used electronic tablets. All communication with residents family members was well recorded. Communication logs also reflected that resident's used telephones and virtual forums to talk with and see their families over the course of lockdown. The designated centre had notice boards which clearly illustrated the photographs of staff on duty across the week, by day and night.

Regulation 26: Risk management procedures

The registered provider had in place a current risk register. All risks were the subject of current review.

Judgment: Compliant

Regulation 27: Protection against infection

Staff hygiene practices were of a good standard and staff training reflected an emphasis on infection prevention control. Many areas of the buildings walls, floors, ceilings and surfaces were compromised and worn. This impacted on the registered providers ability to achieve the standards published by the HIQA.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had good systems and precautions in place against the risk of fire. An upstairs corridor joining two houses, identified as an escape route, had no emergency lights. This matter was noted on the previous inspection but not addressed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

All personal care plans were subject to multidisciplinary review and subject to regular review by residents and their named keyworker.

Judgment: Compliant

Regulation 6: Health care

Each resident had a current healthcare plan in place that was well maintained.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had comprehensive risk assessments in place. Positive behaviour support services were proactive to residents needs in relation to the pandemic and the impact of lockdown, especially if residents exhibited behaviour that challenge.

Judgment: Compliant

Regulation 8: Protection

Inspectors saw two incidents of alleged abuse that had been communicated to advocates by residents, and while the advocates informed the provider, the provider's safeguarding policy had not been implemented.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had in place a recognised support structure to assist residents participate in decisions regarding care and support, however, residents did not have the freedom to exercise choice and control on matters where decisions were taken or not taken at senior management level, relating to accommodation and personal finances.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially 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	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
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	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City North 24 OSV-0005623

Inspection ID: MON-0032267

Date of inspection: 16/12/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Cope Foundation is currently recruiting Social Care Workers to complete the numbers required to meet the care needs of the residents. 2. A number of Social Care Workers who are currently working at the centre through an agency have applied for permanent posts and interviews are currently being arranged. These should be completed by 31.03.2022. 3. Employment agencies have been alerted to the additional requirements and recruitment of suitable candidates will take place as they become available. 4. Recruitment is underway for a replacement for the person in charge and recruitment will commence in March 2022.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. A programme of training for 2022 has been drawn up. 2. Fire training for all available staff (with one exception) was completed by 07.02.2022. Arrangements are being made for the staff member who did not attend training to complete this and as staff return from long term leaves during the year they will each be facilitated to attend fire training in a timely manner. 3. Training that can be carried out online is being managed by nursing management with timelines defined for all staff as to when each programme is to be completed. 4. Nursing management is contacting providers of face to face training within Cope Foundation or other entities if not available in the organisation, to arrange training within	

the timelines in the programme of training. This will be completed by 30.04.2022.
5. All training that is overdue or due in 2022 will be completed by 31.12.2022

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. A review of the current management requirements and systems for support for the person in charge in the centre will be carried out by 31.03.2022
2. The appropriate senior management structure to support and provide oversight for local management will be put in place by 30.04.2022.
3. A clear role description for the person in charge will be provided as part of the recruitment process.
4. Cope Foundation will ensure that a complete induction for the new person in charge is carried out to facilitate them to identify supports within the organization.
5. Systems for local and senior management to respond to the needs and concerns of the residents will be reviewed and appropriate structures put in place, this will be completed by 30.06.2022.
6. The staff carrying out the annual review of quality and safety will meet with residents, their representatives and advocates when carrying out these reviews in future. If there are further COVID-19 restrictions that may impact on these meetings, access via video link will be provided. This access is currently available.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
1. Senior Management in Cope Foundation held a meeting with residents and their advocates on 31.01.2022 at which the new charges for care were set out and the reason for the increases.
2. Cope Foundation have identified a member of staff who will liaise with residents and their advocates regarding their individual assessment of the cost of care.
3. Once these meetings have taken place the residents will be offered the contracts to sign. This will be completed by 30.04.2022.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. All incidents that require reporting to HIQA will be reported within the timeframes set out.
2. A meeting was held with the advocacy service regarding the reporting of allegations of abuse to the person in charge on 13.01.2022. The advocates had reviewed the two incidents highlighted by the inspectors in line with the National Advocacy Service Guidelines and considered that one incident did not meet the criteria of abuse but was rather an example of poor practice. This has been addressed with all care staff by the person in charge. The advocate who reported the other incident stated that the resident refused to give her permission to report the incident and in the light of their confidential relationship she is unable to disclose any further information. The advocacy service has modified their agreement with Cope Foundation to state they will respect the requirement report all allegations of abuse to the person in charge in a timely manner. The advocacy service is currently updating its policy on safeguarding and will share this with the centre when it has been passed by its management board on 31.03.2022. To be completed by 15.04.2022.
3. Advocates agreed at the meeting on 13.01.2022 that their role is to support residents to make complaints and will endeavour to convince and support residents to do same. When residents collectively want the advocates to raise an issue they will continue to do this on their behalf. This is already being addressed with residents at advocacy meetings.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. The Complaints Procedure of Cope Foundation is being integrated into the centre's culture. Staff are reading the policy and signing that they agree to adhere to it and this will be completed for all available staff by 31.03.2022.
2. All staff are currently undergoing the training recommended by Cope Foundation on how to deal with complaints and this will be completed by 31.03.2022.
3. Any complaint raised by residents with the advocates will be transferred to complaint forms and the procedure for dealing with same followed. This is already in place.

Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: 1. Cope Foundation will review policies that require review and carry out these reviews by 31.12.2022. 2. Policies specific to St Vincent's Centre will be reviewed and updated by 31.03.2022.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: 1. All areas that require urgent attention to maintain proper hygiene standards are addressed but the size of the building means that not all surfaces can be completely maintained. 2. All bedrooms and communal areas are checked regularly and reported to Cope maintenance department when work is required to bring the area to minimal standards.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. The light in the corridor will be fitted by 31.03.2022.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: 1. The person in charge has taken note of the finding by the inspectors. 2. All allegations of abuse will be investigated and reported in line with Cope Foundation policy.	

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Senior management met with residents and their advocates on 31.01.2022 and residents were able to question the reasons for the new accommodation costs and the progress towards transition.
2. In discussion of transition to the community residents requested that they be informed as and when houses have been found. Residents have outlined that they do not want regular meetings when all there is to tell them is that there is no progress as they find this stressful. They do want to know as soon as houses are available and they want input to be able to decide where and with whom they live. Senior management at Cope Foundation will ensure that meetings are arranged to inform residents when houses have been located. Agreed on 31.01.2022.
3. Cope Foundation has appointed a person to work closely with the person in charge and residents of the centre to identify appropriate housing and prepare the residents for the transition to the communities they wish to live in. 23.02.2022
4. Cope Foundation senior management and the person in charge have commenced regular 5 weekly meetings the HSE Disability Services to focus on the purchase of suitable housing for the residents of St Vincent’s Centre. Commenced 13.01.2022

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	08/04/2022
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	31/12/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	30/06/2022

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	30/06/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2022
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/06/2022
Regulation	The registered	Not Compliant	Orange	30/06/2022

23(1)(e)	provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.			
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	30/04/2022
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	31/03/2022
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape,	Substantially Compliant	Yellow	31/03/2022

	building fabric and building services.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/03/2022
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	15/04/2022
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	31/03/2022
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Not Compliant	Orange	31/03/2022
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	31/03/2022
Regulation	The registered	Not Compliant	Orange	31/03/2022

34(2)(e)	provider shall ensure that any measures required for improvement in response to a complaint are put in place.			
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.	Not Compliant	Orange	31/03/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/12/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/03/2022
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with	Not Compliant	Orange	31/03/2022

	his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			
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	31/03/2022