Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 18
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	25 February 2021
Centre ID:	OSV-0005628
Fieldwork ID:	MON-0032012

About the designated centre

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

A full-time residential service is provided for adults with an intellectual disability in this designated centre. The centre comprises two bungalows located on a campus in an inner city suburb of a large city. There are two other designated centres comprising five houses and a day service also located on the campus. A maximum of 17 people can live in the centre. On the day of inspection there were seven people living in one bungalow, and nine in the other. Both bungalows were purpose built including accessible bathroom / shower facilities for residents who use mobility aids. The communal spaces in each house included a large sitting room, a spacious sun room, a separate dining room and a kitchen. The centre was staffed with a minimum of three staff in one house and two in the other, by day. Each house had one waking staff member from 20:30 to 08:30, with one additional nursing staff member supporting care by night, in this and a neighbouring centre. The staff team was nursing lead and comprised of nursing staff and care assistants. An activities coordinator was employed full-time between the two houses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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
Thursday 25 February 2021	09:30hrs to 16:30hrs	Michael O'Sullivan	Lead

What residents told us and what inspectors observed

The inspector reviewed previously requested documentation in the registered providers day services in advance of attending one of the residences attached to the designated centre. Social distancing was observed and discussion with residents was limited to 15 minutes each. Hand hygiene was practiced and the inspector and staff wore a face mask and a disposable apron.

The inspector met with seven of the residents living in the centre. Many of the residents had lived in the centre for over 20 years and some had complex health care needs with an increasingly high level of support required. One residents ability to mobilise had greatly diminished and needed the support of two staff when mobilising. The residents spoken with said they were happy living in the centre and enjoyed planned activities. A social development programme for residents had been developed. Residents continued to have an interest in gardening and had developed a sensory garden and had planted flowers and bulbs during the winter. One resident told the inspector that they really liked the garden. Another resident had a sensory room that they and other residents enjoyed using. A therapeutic bath was also used by a resident who particularly enjoyed stimulation with bubbles. All residents looked very comfortable in the presence of staff. All communication and engagements were observed to be gentle, respectful and unhurried.

When the inspector visited one house, all residents were engaged in a table top activity with the three staff members on duty. Residents appeared happy and were smiling. Not all of the residents communicated with words but extended a hand of welcome to the inspector. One resident did vocalise quite loudly but the other residents did not appear disturbed by the noise, at that time. The premises was bright, airy and very clean. There were sufficient communal rooms to afford residents time alone if they choose. The inspector observed that all residents appeared to have access to the kitchen and dining areas with the direct support of staff.

One resident assisted the inspector on their tour of the premises. Each resident had their own bedroom which promoted privacy and dignity. All bedrooms were observed to be homely, bright and personalised with residents possessions and items of importance to them. One bedroom had been recently wall papered by staff in their off duty time. This addition to the bedroom was a source of enjoyment to the resident. Some residents were encouraged to engage in household chores and activities.

Residents did indicate that they missed going home to their families and would have been used to receiving visitors and having weekends at home prior to the pandemic. The inspector contacted two families by telephone. One family member said that they missed seeing their sibling but were adhering to public health guidelines and not travelling beyond five kilometres from their home. They indicated that they had attended a window visit around Christmas time. They stated that the staff kept in

contact and updated them on a regular basis. Staff had been in contact regarding signed consent for a planned medical procedure. They regarded their sibling to be safe and happy in the hands of strangers. Another family were happy with the care and support that their sibling received. The family member acknowledged that staff were good to maintain contact.

In summary, the inspector found that each resident's wellbeing and welfare was maintained to a good standard and that there was a strong and visible person-centred culture within the designated centre. The designated centre was both well run and sufficiently resourced to meet the assessed needs of residents. The inspector found that there were systems in place to ensure residents were safe and in receipt of good quality care and support.

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 inspector found that the designated centre overall, was well managed to meet the assessed needs of residents. There had been significant improvement with regulatory compliance since the previous inspection. Staff demonstrated a good understanding of the residents needs. Residents appeared and stated that they were happy and well supported. The focus of support was person centred in a homely environment. Residents had meaningful engagement with their families and access to the day services and the local community that were impacted by current public health restrictions.

The registered provider had in place a team of staff that were trained to meet the assessed needs of residents. The person in charge was employed in a full-time capacity and had transferred into the service in 2020. The person in charge was an experienced and suitably qualified person. Communication with the person in charge was either face to face or by mobile phone. The person in charges commitment to this designated centre was 50% of a whole time equivalent as they also had responsibility for another designated centre. Staff numbers allocated to the designated centre afforded some person centred care and there was evidence that activities were facilitated in residents homes in the absence of structured day services. The allocation of staff was consistent with the safeguarding and protection needs of residents, however, the allocation of staff in one of the houses was consistently only two staff members to nine residents, with nursing supports visiting from the adjacent house. This provided less opportunity for residents to engage in external activities and ones of individual choice when the activities coordinator was not on duty. The physical needs of one resident required the attention of two staff

at times. Staffing levels were recorded as an ongoing risk on the registered providers risk register for a period of three years, as well as on two previous HIQA inspections.

All notifications had been made to the Chief Inspector, within the required three day period. All reported incidents to the Health Information and Quality Authority (HIQA) were consistent with the registered provider's records on the national incident management system (NIMS). The registered provider had in place a directory of residents that contained all the requirements as specified by Schedule 3 for all 16 residents. Each resident had a current contract of care signed by their family member or representative, with the exception of one resident whose family did not return the contract. A social worker employed by the registered provider was pursuing this matter.

The inspector reviewed a number of complaints that the registered provider had addressed since the previous inspection. The records reflected a prompt response by all staff to adequately deal with complaints to the satisfaction of the complainant. These records also evidenced a person centred approach where the rights of the resident were prioritised.

The registered provider had arranged for six monthly reviews of the designated centre which was conducted in May 2020 and February 2021. It was clear that residents and their families were involved in this process and their views recorded in the document. The person in charge conducted staff performance reviews for all staff and the clinical nurse managers and staff nurses provided supervision to the care assistants. Records were available that demonstrated that team meetings, management meetings and multidisciplinary meetings were taking place and properly recorded. The annual review of service took place in February 2020 and was due to be undertaken in the coming weeks. Improvements that were required were highlighted. Examples included positive behavioural support, restrictive practices and the need for greater accuracy relating to residents healthcare plans. Additionally, areas of improvement were in relation to the scheduling of residents meetings, the advancement of advocacy services and the involvement of family members in person centred planning. It was evident that these matters were been addressed within the time frame determined by the reviewer. Resident meetings were facilitated and recorded. Records reflected that social events, menu planning, self care and the COVID-19 pandemic were all regularly discussed with residents and in an easy to read format. The registered provider had risk rated the lower staffing levels in one house but had not considered the impact on residents care and support in its review of quality and safety of services.

The provider had in place a training schedule for all staff. Mandatory training provided by the registered provider was in part effected by the current COVID-19 restrictions. The training matrix records of 28 staff were reviewed. All staff had current training in fire and safety. 68% of staff needed current training in the management and prevention of aggression. The registered provider was in the process of changing staff training with an emphasis on positive behaviour support which is in line with the residents assessed needs and current presentations. 21% of staff required retraining in relation to safeguarding vulnerable adults. Staff training

records demonstrated recent training in breaking the chain of infection as well as the proper use of personal protective equipment (PPE). All staff had undertaken hand hygiene training. Staff had also undertaken additional training to meet the assessed needs of the residents.

The registered provider had in place a statement of purpose that was an accurate description of the service provided. The conditions of registration were clearly outlined and a copy of the registration certificate was on display in the designated centre. The statement of purpose had recently been revised to support the application to renew the registration of the designated centre.

The registered provider had made an application to renew the registration of the designated centre six months in advance of the current registration end date in compliance with Section 48 of the Health Act 2007. This afforded the protection of the Health Act 2007 to both the residents and to the registered provider.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had made an application to renew the registration of the designated centre six months in advance of the current registration end date in compliance with Section 48 of the Health Act 2007.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had employed a suitably qualified and experienced person in a full-time role.

Judgment: Compliant

Regulation 15: Staffing

The registered provider ensured that the number, qualifications, skill mix and experience of staff was appropriate to the assessed needs of some residents, however the numbers of staff allocated to one house was consistently maintained at minimum staffing levels.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge ensured that all staff had access to appropriate mandatory training, however refresher training was required by staff relating to managing behaviours that challenge and the safeguarding of vulnerable adults.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had in place a current directory of residents.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place effectively monitored the quality and safety of care but the registered provider failed to provide services based on some residents assessed needs. Staffing levels were recorded as an ongoing risk on the registered providers risk register for a period of three years, as well as on two previous HIQA inspections.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider ensured that each resident had in place a contract of care that clearly outlined the terms and conditions of residency.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had in place a current statement of purpose which was

subject to review.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge ensured that the Chief Inspector was notified of all adverse incidents within the specified time frame

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a clear and effective complaints procedure in place for the residents.

Judgment: Compliant

Quality and safety

The inspector noted that there had been an overall improvement in the quality and safety of services since the previous inspection. The focus of service delivery was more aligned with the needs of and the support of residents. Prior to the COVID-19 pandemic, staff had focused on increasing residents' access to the wider community. Residents were attending day services on the campus as well as being individually supported by staff to attend to external activities for example in a community garden allotment as well as keep fit classes. Individual activities in one house were less likely to occur due to the low levels of staff to residents ratio. Planned decoration works had taken place.

The premises provided additional space to residents as a result of reduced resident numbers. One registered bedroom had not been utilised for a number of years and had become a storeroom for walking aids and appliances used by residents. All residents had a single occupancy bedroom. Bedroom spaces had been enhanced and there were additional efforts to personalise residents' bedroom spaces. The house visited was maintained to a very good standard.

Staff were focused on providing residents with meaningful occupation to promote wellbeing and overall health. Residents were asked and supported to attend to minor household chores. General activities had been replaced in line with public

health restrictions. Residents were engaged in more house based and table top activities e.g. baking, arts and crafts, chair yoga. A therapy dog had also attended the designated centre and this was evidenced through a photographic log. The activity records of residents reviewed had reflected an improvement in the level of community based activities, prior to the start of the COVID-19 pandemic. Staff resources were recorded in some staff meetings as the reason preventing such activities occurring which impacted on residents accessing recreational activities and interests of choice.

The inspector reviewed the individual care plans and notes relating to seven residents. The records maintained were to a good standard. It was clear that all residents had been in receipt of regular health assessments and their health needs were reviewed by staff working within their homes as well as allied health professionals. These professional inputs were specific to the assessed physical and medical needs of the residents in question. Clear preventative measures and treatment procedures and strategies were well documented. Residents with identified conditions had clear instructions from their attending consultant on record. Each resident had been the subject of an OK Healthcheck within the previous 12 months. The hospital passports of residents were well maintained.

The registered provider through an audit process had determined that person centred plans required improvement. This issue had also been identified on previous HIQA inspections. It was evident that the person in charge and the activities coordinator were committed to address this matter. A new person centred plan and documents were a work in progress on the day of inspection. It was evident that staff had made efforts to include family members in an annual review process. Improvements were required to ensure that plans met the requirements of regulation, in particular in relation to the setting of personal goals and how these goals would contribute to improving residents quality of life. Many aspects of the work in progress were seen to have good potential in terms of its overall presentation and easy to read format, however person centred planning continued to fall short of regulatory compliance. This had also been the findings of two previous inspections. For example, some records did not reflect what was a defined goal which was sometimes captured as one word, while some goals recorded were a record of activities that the resident had been involved in. While it was evident to the inspector that some activities that the resident was engaged in helped them to achieve a goal, staff were recording the activity as the residents goal. In this case it was difficult for residents and staff to know exactly where the person centred plan was at and what it was trying to achieve.

There were a number of restrictive practices in place in both houses. Each resident had a risk assessment in place that assessed the impact of the restriction on them. Residents or their family member had signed consent forms in relation to the restrictive practice in place. It was evident in some instances, the signed declaration did not contain the detail of all restrictions applied to a resident. For example, a resident and their family had signed a restriction consent relating to a locked kitchen door, the main entrance door and the use of a protective helmet. however the resident was also subject to restrictions in relation to accessing their bedroom, the houses laundry and the staff office. Additionally, the registered provider failed to

identify that some restrictive practices implemented for one resident, was been applied to all residents.

Residents had current safeguarding plans in place that were subject to ongoing review. The staffing levels in one house were specific to the safeguarding measures in place. Safeguarding notifications had been appropriately closed off on the instruction of the Health Services Executive Safeguarding team.

On the day of inspection, it was evident that staff had undertaken training in relation to the proper use of PPE. Staff had also undertaken educational modules in relation to proper hand washing and breaking the chain of infection. Stocks of PPE were held centrally on the campus and it was observed that significant stocks were in place. Hand sanitizer stations were located throughout all houses with staff observed to use these effectively. Clinical waste bins were at each exit for the safe disposal of used PPE. All visitors to a house were required to sign in and have their temperature recorded by a member of staff. Staff allocations were monitored to ensure that there was limited crossover and contact between the staff in each house. Current public health guidelines were seen to be adhered to. Staff familiar to residents had been trained to take COVID-19 swabs. External contract cleaning had been suspended to reduce footfall in the houses. Staff were undertaking all of the cleaning duties and all areas were observed to be very clean. The registered provider also had a daily audit in place of staff adherence to mask use, the ventilation of the houses and the cleaning of frequently touched areas. The person in charge has also completed a self assessment to determine the registered providers readiness to address a COVID-19 outbreak.

On the previous inspection, some fire and safety issues had been highlighted to the registered provider. In response, the registered provider had addressed such areas and all fire doors and seals were observed to be in good condition. Each resident had a clear and current personal emergency evacuation plan. Each house had a weekly fire checklist that staff adhered to. Staff practices were observed to be of a good standard - fire exits were clear and fire evacuation drills were taking place on a monthly basis in line with the registered providers statement of purpose. The fire alarm system, the emergency lighting system and all fire extinguishers had been serviced in the current year. All staff had undertaken mandatory fire and safety training.

Since the previous inspection the registered provider had undertaken a review of its risk register and risk assessment process. The risk register for the designated centre was comprehensive and had been updated in December 2020. The risk register also reflected the COVID-19 pandemic and the risks associated with infection. The risk of self harm was not recorded as a regulatory risk. The person in charge undertook to address this matter.

Regulation 12: Personal possessions

The person in charge ensured that the residents had both access and control of

their possessions.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider ensured that some residents had both the opportunity and facilities to take part in education and recreation activities of their choosing, however one house of residents has less access to individual activities of their choosing.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider ensured that the premises was designed and laid out to meet the assessed needs of the residents, however one house had no storage space for bulky aids and appliances and was utilising an unoccupied registered bedroom.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The person in charge ensured that residents were supported in their choice and variation of food in a service that was well stocked with fresh and frozen food.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had in place an up-to-date residents guide that was available to the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that the arrangements to control risk were proportional to the risks identified within the designated centre, however some regulatory required risks had not been assessed.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider ensured that the residents were protected from healthcare infections by adopting procedures consistent with current public health guidelines.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had in place an effective fire and safety management system.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The personal plan for residents did not reflect the residents needs or outline the supports required by residents to achieve defined goals.

Judgment: Not compliant

Regulation 6: Health care

The registered provider ensured that the residents had an appropriate healthcare plan in place.

Judgment: Compliant

Regulation 7: Positive behavioural support

The registered provider ensured that therapeutic interventions were implemented with the least restrictive method, however some restrictions applied to residents were not recorded or consented to by residents or their representatives.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider ensured that the residents were assisted and supported to develop knowledge, self awareness and skills to self care and protect themselves.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider ensured that the residents participated and consented to their support and care however, some residents did not have the freedom to exercise choice and control over their daily life.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 18 OSV-0005628

Inspection ID: MON-0032012

Date of inspection: 25/02/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • 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. • A meeting has been scheduled for 19/4/2021.	
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, May 18th, June 8th & 17th. All staff in this designated centre will have positive behavior support training completed by 17/6/2021.

• Due to COVID 19 restrictions MAPA training has been restricted for the face-face component however once restrictions have eased, this training will resume.

• All staff have completed online safeguarding training, Safeguarding the Vulnerable Adult and Children's First. Due to COVID 19 restrictions face-face training has been restricted however once restrictions are eased this training will resume. The PIC has requested the appropriate training for staff from the professionals involved to ensure that they are prioritised once restrictions lift .

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.

• It is recognized that the needs of the residents have changed within the centre. The provider has agreed to put forward a specific business case to the HSE for additional resources by 8/5/2021. In the mean -time an immediate action plan has been put in place to ensure that residents have their rights met and a high standard of living. This action plan included the following:

- The residence will be prioritised for relief staff on the days that a third staff can not support from the original staffing allocation.
- The activities, leisure and recreation staff will spend 3 days per week within the house.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development: • The PIC and the team of staff will schedule activities and recreation in in the activation resource rooms onsite which include a gym / activation room and multisensory room. Recreation and leisure activities will also be scheduled in the outdoor garden space, weather permitting. This schedule will be completed by 30th April 2021 and will have due cognizance of each residents' preferences based on their PCP goals and /or support plan.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The provider has reviewed the premises. It is agreed that appropriate storage space is necessary in meeting the needs of the residents. • It has been agreed to reduce the bedroom count/capacity from eight to seven. The eighth bedroom will be used as a storage space for heavier equipment and bulky items. The SOP will be amended by 8/5/21 to reflect this change.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The site specific risk register was reviewed and updated on 22/3/2021 to include the measures and actions in place to control the risk of self-harm. Risk I.D 26.	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • 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 meeting 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, key workers, individuals and their families have completed all PCPS with the exception of one resident who remains at home cocooning with family during the COVID-19 pandemic. Completed by 29/3/2021

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• Positive behavior support training has been scheduled for March 23rd, March 30th, April 8th, April 15th and May 6th 2021, May 18th, June 8th & 17th. All staff in this designated centre will have positive behavior support training completed by 17/6/2021.

Regulation 9: Residents' rights	Substantially 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 May 31st)
• 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 decisions which affect them.
• The PIC will review the restrictive practice log in the designated centre by 30/4/2021 to ensure that restrictions are eliminated where possible and all restrictions are monitored and reviewed on a regular basis.
• Each resident will have an updated list of restrictions in their file which will be signed by the resident's next of kin. To be completed by 30/4/2021.
• Staff will be supported to access the HIQA training on line around "supporting a rights-based approach to care". The notification for the first module has been provided to staff on the internal communications platform (29/3/21)

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/04/2021
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	30/06/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Substantially Compliant	Yellow	17/05/2021

	appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	08/05/2021
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	08/05/2021
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Substantially Compliant	Yellow	22/03/2021
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the	Not Compliant	Orange	30/04/2021

	supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	29/03/2021
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	29/03/2021
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic	Substantially Compliant	Yellow	07/06/2021

	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.			
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	31/05/2021