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:	North County Cork 2
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	20 January 2020
Centre ID:	OSV-0003707
Fieldwork ID:	MON-0024997

About the designated centre

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

North County Cork 2 is comprised of three separate buildings, located within the environs of a large town on the outskirts of Cork City. Local amenities can be easily accessed such as shops, cinema and restaurants.
The largest of the houses can accommodate 13 adults, male and female with an intellectual disability. At the time of the inspection, 12 adults were supported with full time residential care and one bed was available for use to provide short term breaks to adults who avail of services from the provider. It is a purpose built bungalow located in a cul-de-sac surrounded by a large garden area. The house is comprised of 13 individual bedrooms, one with an en-suite. In addition, there is a large kitchen-dining area, two sitting rooms, two bathrooms, two shower rooms, two water closets, a laundry room and a staff office. There is also a visitor area which is comprised of a small kitchen and sitting room which is located off the large reception area.
There is a self-contained apartment adjoining this house which can accommodate three residents. It is comprised of three individual bedrooms, a kitchen, dining-sitting room, a shower room and laundry area. It is connected to the main house by a corridor.
The remainder of the designated centre which is located in another residential area of the town is comprised of two semi-detached houses which have been joined internally and a two storey semi-detached house located next door. The larger house provides support for 10 adults from Monday to Friday and closes each weekend and during holiday periods. The residents are supported to attend day services and return to the designated centre in the evening. This house is comprised of one large sitting room, dining room and kitchen, two bathrooms and one shower room. There are nine bedrooms, six single rooms, two shared bedrooms and a staff bedroom with en-suite. The other house supports two adults and is comprised of three bedrooms , which includes a staff room. There is also a sitting room, dining room with separate kitchen and a bathroom. Each of the houses have parking facilities at the front and a garden area to the rear.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26

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
Monday 20 January 2020	10:05hrs to 18:00hrs	Elaine McKeown	Lead
Monday 20 January 2020	10:05hrs to 18:00hrs	Conor Dennehy	Support

What residents told us and what inspectors observed

On arrival at the larger unit of the designated centre, it was seen that majority of residents living in that unit had left to attend a day service in the local town. The residents that remained were being supported to have breakfast. Residents appeared happy and content at this time. One resident was preparing to return to their family home. However, the staff informed the inspectors later in the morning that a family member was unwell so the resident was supported by staff to attend their day service and they returned to the designated centre in the evening. The inspectors met another resident when they came into the dining room to have a hot drink. The resident showed one of the inspector's their nail varnish, jewellery, hair clip and gently rubbed their own face to emphasise their smooth, soft skin that had been moisturised by staff.

The inspectors had an opportunity to speak to some residents. One resident told an inspector that they liked everything about living in the designated centre and also commented positively on the support that they received from staff. This resident was observed to move freely throughout the unit during the inspection and was also seen to leave the unit with staff and another resident to go into the local town during the day.

A second resident spoken with provided very positive views regarding the centre overall. This resident was seen to relax during the inspection and interacted well with staff members on duty. This resident told the inspector that it was too icy for them to go for a walk into town in the morning as had been planned; the resident was able to go out later in the day. A third resident spoken with talked about going to a day service later in the day which they were seen to do. This resident also indicated to an inspector that they were waiting for a walking aid to help them mobilise around centre and had been waiting for this this since Christmas. Shortly after the resident raised this issue, a physiotherapist arrived to provide the resident with a walker which they were seen to use.

As some of the residents returned in the early evening to the designated centre, they spoke of their day. One resident had attended their reading and writing class; another told the inspector how they like to play their musical instrument and played a few notes in the dining room. One resident spoke of how delighted they were to be going to see one of their favourite bands in concert during the summer with their sister. They explained the concert was fully sold out and they were very lucky to have a ticket for the concert. Another resident who was availing of a short break in the centre spoke of how they used their phone to play games and had plans to visit a relative later in the evening.

Upon leaving the larger unit of the centre at the close of inspection it was seen that most residents living there had returned. Residents were seen to be supported to have their meals while some were relaxing and watching television. A social atmosphere was in evidence during this time and throughout the inspection it was

seen that staff members on duty interacted with residents in a pleasant, warm and respectful manner overall.

One inspector did go to the other houses which are also part of this designated centre during the inspection but did not meet with any of the residents living there at the time as they were all attending their day service.

Capacity and capability

During the inspection, staff were seen to engage with residents in a positive, respectful and warm manner. However, the compliance levels found during the inspection indicated that improvement was required in relation to the remit of the person in charge in addition to the governance and management in place in the centre. Immediate actions were required to be completed before the end of the inspection to ensure risks were reduced to residents living in the designated centre. These included the removal of a bed that was located on a corridor in front of a fire exit and the removal of tape that was covering a smoke detector; the reason for this tape being present was not known on the day of the inspection. The inspectors also requested the removal of a bath mat that was covered in mould, the removal of two containers in the rear garden of one of the houses that contained discarded cigarette ends that were left by staff members. Other issues regarding the premises that were noted during the walkabout with the person in charge were discussed during the feedback meeting at the end of the inspection and will also be referred to in this report.

The provider had a person in charge appointed to this designated centre, at the time of this inspection. This person was also responsible for another designated centre which was 20 kilometers away. North County Cork 2 is comprised of multiple houses located in two separate areas in the town. In light of the compliance levels found during this inspection, this arrangement was not suitable to ensure the effective governance, operational management and administration for the whole designated centre. For example, the person in charge did not have capacity to visit the smaller units in this designated centre on a regular basis. The person in charge had limited opportunities for the supervision of staff. Documentation reviewed by the inspectors saw evidence that some issues identified in scheduled audits did not have actions completed. Also, audit findings reviewed by the inspectors identified issues were re-occurring; for example in financial audits, the omission of double signatures on resident's receipts which is required as per the provider's own policy guidelines. Issues pertaining to the premises that were noted during the inspection, in particular in the smaller houses had either not been reported to the person in charge by staff or the person in charge was not aware of the maintenance issues.

While there was evidence of a consistent, core group of staff available to support the current assessed needs of the residents; the actual and planned rota did not reflect the location of the person in charge or the clinical nurse manager in the

designated centre. In addition, refresher training for staff was not up-to-date in particular in the area of fire training and no training dates had been booked or planned to provide training for those who required it. The changing needs of residents will require regular and on-going review to ensure all residents are continued to be supported.

The statement of purpose did not reflect the management structure in place in the designated centre at the time of the inspection. This was also an action that an audit conducted by the provider in October 2019 had identified and was also referred to in the annual review report following another audit in December 2019. In addition, details regarding some of the houses which are part of the designated centre were not contained within the statement of purpose. The provider had also failed to ensure the current certificate of registration was displayed in the designated centre, an updated certificate had been issued to the designated centre in October 2019.

The provider and person in charge had identified actions and learning from incidents within the designated centre to support residents and reduce the risk of the re-occurrence of similar incidents, such as supporting a resident with an additional staff member early in the morning and monitoring the effectiveness of this support. The inspector was shown evidence of further review resulting in changing the support to meet the changing needs of the resident concerned. However, not all quarterly notifications for 2019 had been submitted by the person in charge to the Office of the Chief Inspector as required by the regulations. The person in charge submitted the notification retrospectively following this inspection.

There were no open complaints at the time of the inspection. The person in charge had recently updated the local complaints policy. On review of the complaints log in one of the houses there was evidence of residents being supported to make complaints. While the date of resolution was documented, the satisfaction of the complainant was not recorded.

While the provider had conducted six monthly unannounced audits in April and October 2019, the completion of actions was not always documented. Some actions were found to still not to be completed in the October audit which included a review and update of the statement of purpose, gaps in administration relating to regulation 23, premises and the directory of residents. The issues were found to still not be completed during this inspection. The provider had completed a quality and safety report in June 2019 and the annual review for 2019 in December but the reports were not available for review on the day of inspection in the designated centre. The provider did make the reports available to the inspectors in the days following the inspection. However, the inspectors were not assured that the provider would ensure findings of these reports would be actioned and completed.

Regulation 14: Persons in charge

The person in charge did not ensure effective governance, operational management and administration of the entire designated centre.

Judgment: Not compliant

Regulation 15: Staffing

There was evidence of a consistent core staff team and at the time of the inspection, staffing arrangements were appropriate to meet the needs of the residents. However, the staffing arrangements in place would require ongoing review given the changing needs of some residents. In addition, the actual and planned rota did not reflect the location of the person in charge or the clinical nurse manager who also had remit over another designated centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

At the time of the inspection not all staff had access to refresher training in fire safety. There were no formal arrangements for the supervision of staff in the designated centre

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents had not been maintained in the designated centre to reflect the name of the person in charge.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems were not in place in the designated centre to ensure that the

service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had not revised the statement of purpose to reflect changes in the management structure of the designated centre. In addition, the document did not contain all the required information as required by Schedule 1

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all notifications had been submitted to the office of the Chief Inspector as required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were no open complaints at the time of the inspection. While complaints had been logged and closed the satisfaction of the complainant was not recorded.

Judgment: Substantially compliant

Quality and safety

Efforts were being made to provide for the assessed needs of residents. However, it was evident that improvement was needed in a number of areas during this inspection. These included the personal planning process, fire safety and the premises provided.

The needs of residents were set out in their individual personal plans which provided guidance on how to support residents in various areas. Such plans are required by the regulations and the maintenance of such plans is a key responsibility of the

person in charge. The provider had ensured that these plans were presented in an easy-to-read format and had multidisciplinary input but individual personal plans must also be subject to an annual review that assesses the effectiveness of such plans and involves the participation of residents and their representatives. Based on the sample of personal plans reviewed such reviews were not happening in a timely manner. For example, for one resident it was seen that the last time they had been involved in the review of their personal plan was January 2018.

Ensuring personal plans are adequately reviewed is important to ensure that any changes in need are identified and responded to as soon as possible. There was evidence that the needs of residents were changing and while staff working in the designated centre had sought to respond to these, this was not always evident in personal plans. As part of the personal planning processes, specific goals were identified for residents but it was not clearly demonstrated that these were being adequately reviewed to ensure that gaols were being progressed and ultimately achieved. It was noted though that some key wishes of residents had been supported such as completing an advocacy course, visiting Lourdes and increased trips away from the designated centre. It was also seen that support was given to residents to maintain their health with residents' health assessed by the provider on an annual basis.

Within residents' personal plans information on supporting residents with assessed health needs was in place which was noted to provide clear guidance. Access to a range of allied health professionals such as general practitioners, physiotherapists, opticians, dentists and chiropodists was facilitated while it was seen that residents were supported to receive certain health interventions, such as receiving vaccines, and to undergo key health screenings that were offered nationally. Residents were also being supported to ensure that they received their prescribed medicines to help maintain their health. As part of this secure storage facilities were provided for medicines to be stored including medicines which required refrigeration. While it was noted that parts of the main storage press in one unit were a little cluttered, a sample of medicines documents were reviewed which indicated that residents' medicines were being given at the correct time in the correct manner.

Some areas for improvements in relation to the management of residents' medicines were seen during this inspection. For example, in a sample of medicines reviewed, which were generally found to be appropriately labelled, it was noted that for one medicine the date on which the medicine was first used was not indicated. Systems were in operation for the temperature of the medicines storage fridge in one unit to be recorded daily but some gaps were evident in documents maintained. Medicines documents that related to specific residents contained all of the required information, such as the residents' name and date of birth, but it was seen that it was not consistently stated if some residents had any allergies on certain documents. It was noted though that residents were being assessed to determine if they could administer their own medicines and appropriate support was given where required.

Instances were also seen where residents had been provided with information around their assessed health needs in an appropriate format. It was found though

that one resident had not been provided with such information on a health screening that they were entitled to while some instances where residents had refused some health related supports had not been clearly documented as required by the regulations. Instances where refusals of such supports had taken place were respected by the provider but inspectors did note some occasions where residents had not sufficiently participated in particular decisions made about their health support. For example, it was noted that the provider had made attempts to provide one resident with a particular aid to support their mobility during 2016. This attempt was stopped after intervention by the resident's family and the issue was not sufficiently reviewed again until 2019 when the same issue was raised by the resident's family. As such for this particular issue it was not demonstrated that the resident had been actively consulted regarding this matter nor that appropriate advocacy had been sought to ascertain if they wanted the particular aid.

Inspectors also noted that one resident was due to undergo a particular health intervention which had been scheduled. While the resident was broadly aware that this intervention, was to happen, they had not been informed as to when the particular intervention was to take place. It had been decided not to tell the resident about this date until closer to the scheduled date after direction from the resident's family. Again, this did not demonstrate that the resident was actively consulted on key matters which directly impacted on them. Evidence was seen though that residents were being consulted around other areas of support. For example, within the designated centre, resident forums, which were facilitated by staff members, were held on a monthly basis where various issues potentially impacting on residents were discussed. These included safeguarding, privacy, food, activities, residents' bedrooms and staff support. These forums provided an opportunity for residents to raise any concerns that they had in such areas.

Fire safety was also another area which was discussed during these resident forums. On the current inspection it was observed that the provider had made improvements to the provision of fire safety in some units of the centre as had been highlighted during the previous inspection. It was also seen that fire drills were being carried out while a personal emergency evacuation plan (PEEP) was in place for each resident outlining the supports required to assist residents to evacuate the centre if required. Training in fire safety had been provided to staff members but it was noted that a number of staff were due refresher training in this area in the week following this inspection and no refresher training had been scheduled. However, during the course of this inspection, some areas were identified by inspectors as requiring improvement to ensure adequate fire safety protection.

On arrival in the larger unit of the centre, a bed was observed to be stored in a hall which led to an identified evacuate route. This potentially obstructed this evacuation route and while this was removed before the close of inspection, the person in charge informed an inspector that this bed had been stored in the hall since the previous month. Fire doors, which help contain the spread of fire and smoke, were present throughout all units but it was seen that some of these required review to ensure that they functioned as attended. Emergency lighting, fire extinguishers and fire alarms were also provided in all units but in one unit it was seen that quarterly maintenance checks were not being carried out consistently on the fire alarm

provided. In another unit it was seen that tape had been placed over a fire alarm sensor thereby reducing its effectiveness. Such observations did not provide assurance that the fire safety systems in place were being monitored effectively or that the risk associated with fire safety were being adequately considered.

It was also noted that a number of aspects relating to the premises provided were in need of improvement. In the larger unit of the designated centre it was seen that there was sufficient communal space and efforts had been made to give the centre an overall homely feel with most parts of this unit well furnished. However, it was observed that a large disused ventilation unit was present in the kitchen area which did not lend itself to a homely feel, the filters on this unit had visible dust particles hanging from it. A cooker was being used under this ventilation unit and an open pot of potatoes was seen by inspectors to be sitting on top of the cooker where dust particles could fall into it. A number of cleanliness and maintenance issues were also apparent in the units of the centre. For example, some walls were in need of repainting, dust was evident in kitchen areas, a shower mat which clearly required replacing and a cooker hood had melted. Storage was also an issue in the larger unit of the centre as evident by the storage of a bed in a hall and some documents relating to residents being stored in an area which did not ensure their privacy. In one of the other units it was seen that the use of a bathtub was not suited to the assessed needs of one resident.

While the use of this bathtub posed a risk it was not adequately reflected in a corresponding risk assessment. The provider is required to have and implement a risk management policy. Such a policy must provide for the identification, assessment and reviews of risks in the designated centre. It was seen that this policy were being adhered to in some aspects. For example, an overall risk register was in place which was specific to the centre while individual risk assessments for residents were provided. However, some risk assessments had not been reviewed in the previous 12 months while, in addition to the bathtub risk, some risks in the areas of choking and refusal to take prescribed medicines did not have risk assessments in place. It was noted though that the level of risk associated with some of these areas was low while the person in charge and staff spoken with had a good awareness of risks present in the centre. Arrangements were in place for the recording and review of any accidents and incidents.

Safeguarding was assessed by the provider as a potential risk impacting residents and evidence was seen that the provider had generally taken appropriate responses to reduce the potential of residents to be subject to abuse. For example, all staff members had been provided with relevant safeguarding training while those spoken with during inspection demonstrated a good awareness of any safeguarding issues present and how to respond to these. Relevant plans were also available to provide guidance in this regard such as safeguarding plans, intimate personal care plans and positive behaviour support plans. While such plans were noted to provide a good level of information in these areas and there were indications that these were informing practice, it was noted that some of these plans had not been updated in over a year or to reflect recent developments.

Support was also given to residents when managing their finances so as to ensure

that they were not subject to financial abuse. Residents had financial assessments carried out to determine the levels of support, if any, that they needed in this area. A sample of these assessments were reviewed and it was noted that these assessments had been conducted within the previous 12 months and identified the supports residents were to receive. Following on from this systems were in place for residents' finances to be tracked and monitored but it had been identified by the provider that part of this process required review to ensure that it was consistently followed by staff and sufficiently robust. However, no evidence of financial abuse was found during this inspection and it was seen that residents appeared comfortable in the presence of staff members on duty who treated residents in a warm and respectful manner throughout this inspection.

Regulation 17: Premises

The registered provider had not ensured the premises was kept clean and in a good state of repair externally and internally. A large disused ventilation unit was present in one kitchen area which did not lend itself to a homely feel while the use of a bathtub in another unit was not suited to the assessed needs of a resident.

Judgment: Not compliant

Regulation 26: Risk management procedures

Risk assessments were in place for some identified risks relating to residents but it was seen that some of these risk assessments had not been reviewed in over a year. It is was also noted that some risks which were known were not reflected in a risk assessment. The findings regarding fire safety in this centre did not provide assurance that the associated risks in this area were being adequately monitored and considered.

Judgment: Not compliant

Regulation 28: Fire precautions

Some of the fire doors present in the designated centre required review to ensure that they functioned as intended. The fire alarm in one unit had only received quarterly maintenance checks on three occasions in 2019. In another unit some tape had been placed over a fire alarm sensor. A bed had been left stored in a hall which potentially obstructed an evacuation route.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Residents were being assessed to determine if they could administer their own medicines. Secure storage facilities were provided but t was noted that parts of the main storage in one unit were a little cluttered. For one medicine it was noted that the date on which the medicine was first used was not indicated. There were some gaps in records maintained for the daily temperate recording for a medicines fridge. Medicines documentation contained all of the required information but it was noted that it was not consistently stated if some residents had any allergies on certain documents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal plans were not being reviewed on an annual basis in a manner that assessed their effectiveness and involved the participation of residents and their representatives. While goals were identified for residents, some of these goals had not been reviewed in over a year while for some goals it was not evident if they had been achieved or not.

Judgment: Not compliant

Regulation 6: Health care

Residents health needs were assessed on a yearly basis and residents were facilitated to access a range of allied health professionals, undergo particular health interventions and participate in screening services. Efforts were made to provide residents with information around their health supports but it was seen that one resident was not given information regarding a screening service. Some instances where residents refused some health supports were not documented.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents had positive behaviour support plans to guidance staff practice in this area and promote positive behaviour amongst residents. Staff members spoken with had a good awareness of these plans and it was noted that staff were also provided with relevant training in de-escalation and intervention.

Judgment: Compliant

Regulation 8: Protection

Staff members had been provided with relevant safeguarding training while those spoken with had a good knowledge of any safeguarding concerns. One safeguarding plan had not been reviewed to reflect recent developments while an intimate care plans had not been reviewed in over a year. Residents were supported around their finances but it was noted that the systems in place require review to ensure that they were consistently followed.

Judgment: Substantially compliant

Regulation 9: Residents' rights

For some residents it was not demonstrated that these residents actively participated in decisions around aspects of their care and support or that appropriate advocacy had been sough. Some information relating to residents was stored in a manner that did not ensure their privacy.

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	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for North County Cork 2 OSV-0003707

Inspection ID: MON-0024997

Date of inspection: 20/01/2020

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 14: Persons in charge	Not Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:

• With regard to North County Cork 5 (20 kilometers from Mallow) the second centre which the current PIC is responsible for an experienced staff member who has worked in the centre over a number of years and who has the prescribed qualifications and experience will be assigned the role of Person in Charge, and will be responsible until the return of the original Person in Charge. The newly appointed PIC will work 39 hours per week in the centre over both shifts. Additional support will be available from a CNM1 who is based in North County Cork 2.

• With regards to Cork County North 2 the current Person in Charge will be based on-site and will now be in charge of 1 designated centre. The PIC will divide the week evenly between the two separate locations which make up the 1 designated centre in order to provide effective oversight. Additionally, support will be given by the current CNM1 based in North County Cork 2 and in North County Cork 5. The CNM1's primary base will be North County Cork 2

• Governance & Risk Management meetings have been established with terms of reference and agenda and are scheduled to occur monthly with the attendance of the PPIM. Agenda includes risk management, updating of care plans and person-centered plans, site specific risk registers and schedules of auditing and monitoring. Additionally, the PPIM will schedule every 2 weeks in North Cork to meet with both persons in charge to provide on-going support.

A walk around audit was completed by management on 25/02/2020 and documented with any actions identified. Same is scheduled to occur monthly and actions will be reviewed and followed-up at Governance & Risk Management meetings.

Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The actual and planned rota was updated on 20/02/2020 to reflect the location of the person in charge and the clinical nurse manager on any given day.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Fire Safety training was completed for 13 members of staff on 17/02/2020. 2 staff attended Fire Safety training on 26/02/2020. 8 staff are scheduled to attend Fire Safety training on 04/03/2020. • A schedule for staff performance management meetings was developed on 24/02/2020. Performance management will be completed with each member of staff by 15/04/2020.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: Directory of residents was updated on 19/02/2020 to reflect the name of the person in charge.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Regarding North County Cork 5 (20 kilometers from Mallow) the second centre which the current PIC is responsible for, it has been arranged that an experienced staff member, who has the prescribed qualifications and experience will be assigned the role of Person in Charge and will be responsible until the return of the original Person in	

Charge. The newly appointed PIC will work 39 hours per week in the centre over both shifts. Additional support will be available from a CNM1 who is based in North County Cork 2.
• With regards to Cork County North 2 the current Person in Charge will be based on-site and will be in charge of 1 designated centre. The PIC will divide the week evenly between the two separate locations which make up the 1 designated centre in order to provide effective oversight. Additionally, support will be given by the current CNM1 based in North County Cork 2 and in North County Cork 5. The CNM1's primary base will be North County Cork 2
• Governance & Risk Management meetings have been established with terms of reference and agenda and are scheduled to occur monthly with the attendance of the PPIM. Agenda includes risk management, updating of care plans and person centered plans, site specific risk registers and schedules of auditing and monitoring. Additionally, the PPIM will schedule every 2 weeks in North Cork to meet with both persons in charge to provide on-going support.
• A walk around audit was completed by management on 25/02/2020 and documented with any actions identified. Same is scheduled to occur monthly and actions will be reviewed and followed-up at Governance & Risk Management meetings.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• An updated Statement of Purpose was made available in the centre on 10/02/2020 which reflected the changes in the management structure

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Quarterly Reports for Quarter 3, 2019 were submitted to HIQA on 21/01/2020.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints form was updated on 06/02/2020 to document whether or not the complainant was satisfied with the outcome of the complaint.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Large kitchen ventilation unit was cleaned by external contractors on 13/02/2020 and damaged part of small kitchen ventilator was removed on 20/02/2020.
• Site Specific Risk Register will be updated by 28/02/2020 and will reflect any potential risks with regard the use of bath tubs in the centre.
• A cleaning schedule was updated for staff on 20/02/2020 and same is being recorded accordingly and will be audited by management
• A walk around audit of premises will be completed by management on 28/02/2020 with any actions identified documented. Same will be scheduled for completion monthly.
• Request for painting was forwarded to facilities on 19/02/2020.
A quotation was obtained for the refurbishment and refitting of the kitchen in one house. This included new kitchen units, new electrical fittings and new flooring, and re-painting. Same was forwarded to facilities and approved and is scheduled to be completed by 30/04/2020.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• A full review of resident care plans has commenced and 4 care plans were updated by 19/02/2020 which included a full review of resident individual risk assessments.
• All updated risk assessments are signed and dated and have an identified date for review. All care plans in the centre will be updated by 30/04/2020.
Governance & Risk Management meetings have been established with terms of reference and agenda and are scheduled to occur monthly with the attendance of the divisional manager. First meeting is scheduled for 02/03/2020 and is scheduled to occur monthly. Agenda includes risk management, site specific risk registers and schedules of auditing and monitoring.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire Safety training was completed for 13 members of staff on 17/02/2020. 1 staff attended Fire Safety training on 26/02/2020. 9 staff are scheduled to attend Fire Safety training on 04/03/2020.
• All fire doors were reviewed and repaired on 20/01/2020.
Fire safety maintenance checks for Quarter 01 2020 are scheduled for 28/02/2020 and will be scheduled quarterly for the remainder of 2020.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• A walk around audit of premises was completed by management on 25/02/2020 and documented with any actions identified. Same will be completed every month and will include review of all medications, medication administration records and audit of the recording of the medication fridge temperature.
Each resident will have an updated self-medicating risk assessment completed by 30/04/2020. This will include a risk assessment for the refusal of medication where required.

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:
A full review of resident care plans has commenced and 4 care plans were updated by 19/02/2020 which included a full review of resident health assessments, health support plans and individual risk assessments. All care plans within the centre will be updated by 30/04/2020. Updated person centered meeting template was provided and every resident will have an up-to-date person centered planning meeting completed by 30/04/2020.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Where a resident has a health intervention scheduled this will be communicated to that resident in a timely manner and easy-read information relevant to that particular health intervention will be provided. This will be documented accordingly within the residents care plan. Where a resident, or the residents representative, expresses concern about a scheduled intervention this will be documented and discussed and escalated to MDT level where necessary.
• A protocol was put in place on 26/02/2020 whereby any resident's refusal of prescribed medication was documented and GP was informed of same. Any resident who has previously refused medication will have a risk assessment for the refusal of medication completed by 05/03/2020.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• A full review of resident care plans has commenced and 4 care plans were updated by 19/02/2020 which included an updated intimate care plan. All care plans within the centre will be updated by 30/04/2020.
• All safeguarding plans will be reviewed by 15/03/2020 and reviewed again accordingly should there be any changes to same.
Existing system for accessing resident funds was reviewed on 26/02/2020. New protocols will be put in place to provide additional control measures around accessing money and the recording of expenditure. This will be completed by 10/03/2020.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Resident forums are held monthly in the centre. Resident forum agenda was reviewed and updated on 26/02/2020 to include safeguarding and protection, rights, complaints, grievances and access to external advocacy.
• Person in charge is liaising with advocacy services to arrange an advocate to chair advocacy groups within the centre. This will be completed by 31/03/2020.
All resident personal information was moved to central storage within the nurse's office.

This was completed on 25/02/2020. All older documentation was sent to central filing within the organization. This was completed on 26/02/2020.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	23/03/2020
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	20/02/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including	Not Compliant	Orange	04/03/2020

	refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	15/04/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/04/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	13/02/2020
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise	Not Compliant	Orange	17/04/2020

	disruption and inconvenience to residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/04/2020
Regulation 19(1)	The registered provider shall establish and maintain a directory of residents in the designated centre.	Substantially Compliant	Yellow	19/02/2020
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	23/03/2020
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	15/04/2020
Regulation 26(2)	The registered	Not Compliant	Orange	30/04/2020

	provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	28/02/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	28/02/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	28/02/2020
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt,	Substantially Compliant	Yellow	30/04/2020

	prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	10/02/2020
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	21/01/2020
Regulation 31(3)(b)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each	Not Compliant	Orange	21/01/2020

	calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which the fire alarm equipment was operated other than for the purpose of fire practice, drill or test of equipment.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	21/01/2020
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	06/02/2020
Regulation	The person in	Not Compliant	Orange	30/04/2020

05(6)(b)	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.			
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.	Not Compliant	Orange	30/04/2020
Regulation 06(2)(c)	The person in charge shall ensure that the resident's right to refuse medical treatment shall be respected. Such refusal shall be documented and	Substantially Compliant	Yellow	06/03/2020

	the matter brought to the attention of the resident's medical practitioner.			
Regulation 06(2)(e)	The person in charge shall ensure that residents are supported to access appropriate health information both within the residential service and as available within the wider community.	Substantially Compliant	Yellow	26/02/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	15/03/2020
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	30/04/2020
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability	Not Compliant	Orange	31/03/2020

	participates in and consents, with supports where necessary, to decisions about his or her care and support.			
Regulation 09(2)(d)	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 access to advocacy services and information about his or her rights.	Substantially Compliant	Yellow	31/03/2020
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 her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	26/02/2020