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North County Cork 3, OSV-0003314, 04 November 2021

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

Issued by the Chief Inspector

Name of designated centre:	North County Cork 3
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	04 November 2021
Centre ID:	OSV-0003314
Fieldwork ID:	MON-0029873

About the designated centre

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

The designated centre was a purpose built house to accommodate four residents. It was located adjacent to a large town and in close proximity to a day service facility that residents attended. Each resident had a single bedroom with en-suite facilities. Three bedrooms were located on the first floor in proximity to a staff sleepover room. One bedroom was wheelchair accessible and located on the ground floor. The ground floor also comprised of an office, sitting room, dining room and sunroom. There was a large kitchen, two toilets and a laundry room. The house was decorated and maintained to a very high standard. The centre provided short-breaks and respite to adult male and female residents. The centre was open for three nights on alternate weeks. It was also open for two weekends every month. The staff team was nurse led and comprised of care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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 4 November 2021	2:00 pm to 7:30 pm	Michael O'Sullivan	Lead

What residents told us and what inspectors observed

This designated centre comprised of one house. The inspector and staff wore personal protective equipment (PPE) and direct interactions were limited to periods of time less than 15 minutes in areas that were well ventilated.

The inspector met with all three residents who were availing of respite services. Two residents spoke freely with the inspector. Both said they enjoyed attending the respite service. One resident lived locally and said they were used to attending day services and then spending the night or nights in respite.

One resident spoke extensively about how their life had been since the start of the pandemic and since they had last met the inspector on the previous inspection. This resident had sadly lost both of their parents. They talked about living alone and being supported through day services and respite services. This resident missed working in a local public house but hoped to resume work in the near future. The resident was hopeful that a full-time residential place might be offered to them. This resident showed the inspector their electronic tablet which allowed them access to country music which they liked. Internet access had been introduced to the designated centre since the previous inspection. This resident also had a strong interest in sports and soccer particularly, which they were able to livestream. This resident had plans to spend Christmas in Scotland with their sister.

All residents appeared comfortable in each others company. Staff supported residents with interests of their choosing and this was facilitated through having two staff on duty. Staff were rostered in a sleepover and waking capacity that afforded one resident additional support if they were unable to sleep. This also ensured that other residents sleep was undisturbed. Residents indicated that they liked to wind down after a day in the day service.

Residents were observed to be comfortable within the designated centre. Each resident had their own bedroom with ensuite facilities. Residents had unrestricted access to all areas including the kitchen. Staff were observed to be vigilant but respectful of allowing residents personal space to relax. Staff prepared an evening meal while residents relaxed and watched television or used their electronic tablets.

In summary, the inspector found that each resident's wellbeing and welfare was maintained. The designated centre was run 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 care and support in the house, however the overall governance and management of the designated centre was impacted through the prolonged recruitment of a person in charge. This resulted in a management arrangement where a temporary person in charge had direct responsibility for two designated centres as well as overall responsibility for the management of nine designated centres and six day services. Additionally, there was no evidence

available to confirm that all mandatory checks on agency staff had been undertaken.

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 resourced to meet the assessed needs of residents with the exception of current management arrangements. The person in charge was acting in a temporary capacity while awaiting the permanent appointment of a recruited candidate. While this appointment was pending, the overall management of the designated centre was attributed to one manager and stretched across fifteen separate services. It was evident that staff meetings and the ongoing appraisal of staff performances and staff support were impacted by this arrangement. Staff met on inspection demonstrated a good understanding of the residents needs, however mandatory required information and documents relating to agency staff were not available. Residents appeared and stated that they were happy and well cared for. The focus of care was person centred.

The registered provider had in place a small team of care staff that were well trained. Staff numbers allocated to the designated centre afforded person centred care and there was evidence that activities of choice were facilitated. Residents said that they felt safe and well supported by staff. The registered provider had increased the staff on duty in the evening times to provide one to one support to a resident who had a history of vocalisation and poor sleep patterns. The registered provider also used agency staff to fill gaps in rosters or at times when residents required addition staff support. Residents were familiar with these staff and knew them by name. This ensured continuity of care and limited disruption to residents. The inspector requested from the registered provider the mandatory documents relating to agency staff currently employed in the designated centre. The registered provider confirmed that they were not in possession of the documentation.

The provider had in place a training schedule for staff. Mandatory training provided by the registered provider had not been effected by the COVID-19 restrictions. The training records of staff were reviewed. One staff member required refresher training in fire and safety and a course was booked in the coming weeks. Staff had current training in the management and prevention of aggression and had current training in relation to safeguarding vulnerable adults. Staff training records demonstrated recent training in hand hygiene as well as the proper use of personal protective equipment. One staff member had undertaken training to discharge the lead role of worker representation pertaining to COVID-19. Staff had undertaken additional training to meet the assessed needs of residents in areas of manual

handling and the safe administration of medicines. It was noted that one staff member had attended additional training in response to an adverse incident in the designated centre. Six monthly unannounced audits and the annual review of the service were undertaken and areas for improvement were identified. All areas were actioned and some awaited completion. The registered provider also reviewed areas on non compliance as identified in the previous Health Information and Quality Authority (HIQA) inspection. The report did demonstrate a comprehensive review of the quality, safety of care and support in the designated centre. Recorded staff meetings were not taking place between the person in charge and staff. Staff supervision was not taking place. A new person in charge was recruited and the registered providers intent was to have this person commence in the designated centre in the current month with responsibility for two designated centres.

The provider's statement of purpose was current and accurately reflected the operation of the centre on the day of inspection. The person in charge had ensured that the statement of purpose was updated. The directory of residents was well maintained and all relevant information was current. The current certificate of registration was clearly displayed in the hallway of the designated centre.

The provider had in place a complaints policy and all complaints were well documented in a complaints log which was up-to-date. How to make a complaint was displayed in an easy-to-read format in the designated centre. While there were no formal complaints recorded since the previous inspection, the person in charge indicated that they had received phone calls from families relating to a request for additional respite or registering dissatisfaction with the lack of access to services during the pandemic and lockdown. These representations were not recorded as part of the complaints mechanism. Details on how to contact a confidential recipient were also on display. The information was clear on how an appeals process could be accessed.

Notifications of incidents arising per regulation 31 were notified to HIQA. Appropriate safeguarding actions were implemented by the provider and this was evident through the allocation of additional staff resources during the evening and night time. The registered provider had also responded to an adverse incident that had impacted on one resident. This involved the retraining of staff and the introduction of a revised protocol in relation to the safe administration of medicines.

The registered provider had agreed in writing with each resident and their representatives, the terms and conditions of residency. While it was noted on the previous inspection that residents were not charged for a respite service, the person in charge had undertaken to provide each resident with a local contract outlining conditions of residency. Contracts were noted to be clear and easily understood by residents and their representatives.

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.

Regulation 14: Persons in charge
The registered provider had employed a person in charge in a full-time capacity who was suitably qualified and experienced for the role.
Judgment: Compliant
Regulation 15: Staffing
The registered provider had not ensured that the qualifications, skill mix and experience of staff was appropriate to the assessed needs of the residents. Confirming mandatory documentation was not available from an employment agency at the time of staffs employment.
Judgment: Not compliant
Regulation 16: Training and staff development
The person in charge ensured that all staff had access to mandatory training.
Judgment: Compliant
Regulation 19: Directory of residents
The person in charge maintained an accurate an up to date directory of residents who used the respite service.
Judgment: Compliant
Regulation 23: Governance and management
The registered provider had ensured that the designated centre was properly resourced to provide effective and safe care to residents, however governance arrangements were stretched while awaiting the appointment of a full-time person in charge. This impacted on direct staff supervision, staff meetings and staff

appraisal. The registered provider had not ensured that information and documents relating to agency staff were in place which meant that the systems in place were not safe.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

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

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place that was subject to annual review and accurately reflected the current provision of services due to the pandemic.

Judgment: Compliant

Regulation 31: Notification of incidents

The registered provider had ensured that all notifiable incidents had been made to the office of the Chief Inspector within three working days of occurrence.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a complaints log that was maintained by the person in charge, however, verbal complaints from families were not formally recorded.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found evidence of a good service. The provider ensured that the focus of care was person-centred and specific to the identified needs of the residents. The person in charge and the staff team worked effectively and residents enjoyed attending respite services. The assessed needs of residents were taken into account when offering a respite service and some residents were cohorted on the basis of compatibility. The registered provider's response to adverse events that involved residents, assured the inspector that the designated centre was safe. The registered provider had sought funding to expand the existing respite service as well as the provision of additional full-time residential placements based on residents assessed needs and wishes. A response was awaited from the primary funder.

The premises was clean, bright and homely. There were communal spaces to accommodate all of the residents as well as private areas. Each room had comfortable furnishings. The premises overall was in a very good state of repair and the external gardens were well maintained. Additional external cleaning works as noted in the registered providers annual review had been requested of the maintenance department.

Personal care plans were in place and reflected clear information about each resident. Goals identified in the residents day service plans were meaningful and had been discussed with the resident and their family. A number of care plans reviewed reflected the residents' goals, personal development and wishes. The primary focus of person centred planning was to promote a safe and enjoyable respite stay.

Positive behavioural support plans were reviewed for residents who could display behaviours that challenge. Files reviewed had a behavioural support plan in place. There was evidence that the plan was implemented by staff using the strategies recommended. Restrictive practices employed in the designated centre had been reported to HIQA since the last inspection. The registered provider had in place a restrictive practices log. It was noted that the restrictions applied and recorded were generic and related to the service as opposed to each individual resident. As a consequence, restrictive practices and their impact were not assessed in relation to individual residents. No resident had a record of a risk assessment in place particular to the restrictive practices imposed. Residents consent had not been sought. This was not consistent with the registered providers own policy pertaining to human rights restrictions. This matter had also been identified within the registered providers annual review of the safety and quality of services to residents, but had not been actioned.

Residents had both choice and variety in the food they ate, which was prepared in the designated centre. Food included a range of fruit and vegetables. Residents had access to the kitchen with staff supervision.

The registered provider ensured there was access for residents to avail of occupation and recreation. Residents were supported to attend day services from

the respite centre. There was evidence of inclusion with the wider community and residents recorded activities reflected engagement with the community prior to COVID-19. Many of these activities had been curtailed due to the COVID-19 pandemic, however, residents were starting to access community activities with the support of staff. This was subject to risk assessment and in line with current public health guidelines. Activities were based on residents' preferences and likes.

The provider had up-to-date risk assessments and a risk register. The risk register was reviewed and it was noted that the registered provider had failed to identify and assess risks relating to gaps in governance and management while awaiting the recruitment of a permanent person in charge. The risk of an impact of medicines errors on residents was not updated despite an adverse incident arising in the designated centre. The risk register had been updated to include assessment and actions relating to COVID-19.

It was evident that residents and staff were familiar with infection prevention strategies to reduce the risk of infection. Staff hand hygiene practices and the use of personal protective equipment was observed to be of a good standard. The designated centre was very clean and staff had a regular routine and records logged of additional cleaning applied to regularly touched areas. Staff described the dilution and cleaning agents used both to clean surfaces and disinfect surfaces. Residents, their families and staff completed COVID-19 questionnaires. The registered provider had also undertaken a recent self assessment in relation to COVID-19 preparedness. On the day of inspection it was noted that staff failed to record the temperature of residents attending for respite.

Effective fire safety arrangements were in place in the centre with all equipment being regularly serviced to ensure it was in full working order. A registered contractor had serviced all fire equipment within the previous 12 months and servicing was scheduled in the coming month. Residents participated in regular fire drills which ensured they could be effectively evacuated from the centre in circumstances such as when minimum staffing levels were on duty. Each resident had a personal emergency evacuation plan in place. This was an action identified and arising out of the registered providers annual review of the service. The designated centre's evacuation procedure was clear to both residents and staff.

Residents had adequate storage for their personal possessions. Residents could communicate with their family by phone and also had access to the internet. There were a number of televisions in communal areas that residents had access to. Notices in the designated centre were in an easy-to-read format. Residents had access to a residents guide. The guide available did not contain regulatory required information pertaining to complaints and the previous person in charge was listed as the person who could be contacted. The impact of the pandemic was not reflected in the information relating to visits and visitors.

The registered provider had a policy in place for the safe administration of medicines. This policy had been augmented by a new protocol that was known and signed by staff to reduce the possibility of medicine errors.

Regulation 10: Communication
The registered provider ensured that each resident was assisted and supported to communicate in accordance with residents needs and wishes
Judgment: Compliant
Regulation 13: General welfare and development
The registered provider ensured that the residents had both the opportunity and facilities to take part in recreation activities of their choosing.
Judgment: Compliant
Regulation 17: Premises
The registered provider ensured that premises were designed and laid out to meet the assessed needs of residents.
Judgment: Compliant
Regulation 18: Food and nutrition
The person in charge ensured that residents were supported to buy, prepare and cook food. Residents had a diet that afforded variety and choice.
Judgment: Compliant

Regulation 20: Information for residents

The registered provider had a residents guide that required updating and correcting.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had in place a risk management policy, however, identified risks relating to adverse incidents that had occurred in the designated centre did not have corresponding measures and actions recorded in the current risk register.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider ensured that all residents were protected from the risk of healthcare and COVID-19 infection, however, on the day of inspection it was observed that residents temperatures were not recorded.

Judgment: Substantially compliant

Regulation 28: Fire precautions

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

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider ensured that the designated centre had appropriate and suitable practices relating to the receipt, prescribing, storage and administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that residents personal plans were relevant to residents respite stay and were subject to annual review.

Judgment: Compliant

Regulation 6: Health care

The registered provider ensured that each resident had a healthcare plan that was based on the residents personal plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

The registered had restrictive practices in place and these were recorded in a generic restrictive practices log. Residents consent had not been sought, nor were their individual risk assessments for each resident to determine the impact the restriction may have. Restrictions were not reviewed as part of the care planning process.

Judgment: Not compliant

Regulation 8: Protection

The registered provider ensured that each resident was assisted and supported to protect them from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider ensured that the designated centre was operated in a manner to respect each resident.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	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	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for North County Cork 3 OSV-0003314

Inspection ID: MON-0029873

Date of inspection: 04/11/2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ul style="list-style-type: none"> • The person in charge shall ensure that she has obtained in respect of all staff the information and documents specified in Schedule 2. • Information and documents specified in Schedule 2 are held centrally in HR and are available on request by the PIC. • If a new member of staff or an agency staff join the team the PIC takes the responsibility to contact the HR department to ensure these documents and information are updated accordingly and yearly. To be completed by 31/1/2022 • 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. • Additional support will be employed if required depending on the assessed care needs of the resident availing of respite. 	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> • A suitably qualified CNM 2 has come through the recruitment process and paper work is currently being processed to be appointed as PIC. To be completed by 15/1/2022 • The PIC / PPIM will have monthly 1: 1 meeting to ensure effective governance and oversight of the designated centre. This meeting will focus on effective and efficient staff rostering, HIQA action plan and Reg 23 reviews. An action plan will be developed after each meeting with clear timelines and deliverables. This will ensure oversight by the provider around staffing and HIQA compliance action plans within the centre in delivering 	

on safe, effective high-quality services and supports for people.	
Regulation 34: Complaints procedure	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <ul style="list-style-type: none"> • All complaints will be written in the complaints log and followed up using Cope Foundations complaints policy which will be dealt with in a timely manner by the staff on duty / PIC or supported by the PPIM or the Complaints Officer within Cope Foundation. A local Policy will be written up by the PIC to reflect same so all staff on duty are familiar with the policy. • To be completed by 31/1/2022. 	
Regulation 20: Information for residents	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 20: Information for residents:</p> <ul style="list-style-type: none"> • The residents guide will be updated to reflect current updated information for the residence. • To be completed by 31/2/2022. 	
Regulation 26: Risk management procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <p>The registered provider had in place a risk management policy, however, identified risks relating to adverse incidents that had occurred in the designated centre did not have corresponding measures and actions recorded in the current risk register.</p> <ul style="list-style-type: none"> • The risk register will be updated to include all risks relating to adverse incidents that have occurred in the designated centre . To be completed by 28/2/2022. 	

Regulation 27: Protection against infection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <ul style="list-style-type: none"> • All staff have completed mandatory training with regard to COVID- 19 in ensuring we meet our infection prevention and control standards. • A local policy on monitoring residents' temperatures on a daily basis will be written up by the PIC. Staff will monitor and record temperatures daily as set out by the PIC in the local policy. To be completed by 15/1/2022. 	
Regulation 7: Positive behavioural support	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <ul style="list-style-type: none"> • Each resident who attends for respite will have updated risk assessments which will reflect the current restrictive practices within the residence. • To be completed by the PIC for each respite resident and added to the restrictive practice log. • Residents will be presented with the restrictions which are within the residence and same will be discussed with residence and their guardian. An opportunity will be offered to sign and agree with restrictions within the residence. A copy of this document will be held in the resident's care plan. • Master copy of log held central within Cope Foundation will be updated. • To be completed by 31/1/2022 for each resident who attends respite. 	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/01/2022
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	15/01/2022
Regulation 20(2)(e)	The guide prepared under paragraph (1) shall include the procedure respecting complaints.	Substantially Compliant	Yellow	15/01/2022
Regulation	The guide	Substantially	Yellow	15/01/2022

20(2)(f)	prepared under paragraph (1) shall include arrangements for visits.	Compliant		
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	15/01/2022
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	15/01/2022
Regulation 26(1)(b)	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	Substantially Compliant	Yellow	28/02/2022

	control the risks identified.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	15/01/2022
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	31/01/2022
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative,	Not Compliant	Yellow	31/01/2022

	and are reviewed as part of the personal planning process.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	31/01/2021