Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 16
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	15 November 2023
Centre ID:	OSV-0003292
Fieldwork ID:	MON-0040870

About the designated centre

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

Cork City North 16 is located in a residential setting on the outskirts of the city and consists of two adjoining bungalows which provide a home for up to four adults. The centre is comprised of four single bedrooms, two bathrooms, kitchen-dining room, sitting room, activity room, utility room, staff toilet and office. There is a secure garden area to the rear of the property and small grassed area at the front with parking facilities. The centre is registered to provide a full-time residential service to four residents. Residents are adults with an intellectual disability who may also have additional multiple and complex needs. The centre aims to provide a high quality service in partnership with families and carers, with each resident being valued for their own uniqueness.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 November 2023	10:30hrs to 19:30hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

This designated centre was last inspected on behalf of the Chief Inspector of Social Services (the Chief Inspector) in May 2022. This unannounced inspection was completed to monitor the provider's implementation of the compliance plan it submitted following that inspection, and also to assess other areas of regulatory compliance. The findings of this inspection will inform the Chief Inspector's response to the provider's application to renew the registration of the centre for another three-year period.

In May 2022 it was found that the operation of this service was not compliant with five regulations. As a result, the provider entered regulatory escalation processes at that time. Although improvements were noted in some areas, the findings of this inspection indicated that non-compliances with the regulations remained in three of these areas, namely governance and management, fire precautions, and staff training. Other non-compliances were also identified. These related to notification of incidents, and medicines and pharmaceutical services. Following the inspection an urgent action was issued regarding medication management practices in the centre. This required the provider to confirm what actions they had taken, or proposed to take, within a time specified by the Chief Inspector to address a significant non-compliance with the regulations. The findings that prompted this action are outlined in the 'Quality and Safety' section of this report.

Cork City North 16 is a single-storey house in a residential area on the outskirts of Cork City. Originally it was two semi-detached houses, however was now one detached building. The centre was registered to accommodate four adults. Four residents lived in the centre. Although all four residents could access a full-time residential service in the centre, at the time of this inspection one resident chose to spend the majority of the week in their family home, staying in the centre from Friday to Monday morning. Up until March 2020 a short-breaks / respite service had also been provided in the centre. As requested at the time of the last inspection, the provider had submitted an application to vary the registration conditions of the centre to reflect the service currently provided.

On arrival the inspector was welcomed to the centre by a member of the staff team. Later in the morning the person in charge met with the inspector. Upcoming plans to change the management arrangements in the centre were discussed with the inspector. These would involve a change to the person in charge, and the person participating in the management of the centre. The provider had informed the Chief Inspector of these planned changes. Later in the inspection another manager came to the centre. This inspection was facilitated by the current person in charge and the incoming person participating in management.

Shortly after they arrived in the centre, the inspector walked around the premises. It was noted that some areas identified as requiring improvement at the time of the last inspection in May 2022 had been addressed. There were a number of communal

rooms in the centre including a living room, kitchen and dining room, an activity room, and two bathrooms. The centre was decorated in a homely manner with comfortable furniture, televisions, and soft furnishings available. Each resident had their own bedroom. These were decorated and furnished in line with residents' preferences and assessed needs. Family photos, decorations, and preferred items were available. As was seen in May 2022 some wardrobes were missing handles, parts of the centre required painting, the surface of a kitchen counter was still damaged, and not all fire doors closed fully. The inspector was informed that replacement handles had been fitted to wardrobes but had broken again. These repair works and painting were due to be completed in the coming weeks. Management arranged for the fire doors to be fixed on the day of the inspection. There was no plan in place to repair or replace the kitchen counter. It was also observed that flooring was damaged in a number of rooms. Management advised that new flooring had been requested but there was no timeline for this to be provided. Other areas requiring maintenance identified included a number of damaged surfaces in the activity room and rusted fittings in a bathroom. While in the activity room it was identified that the external door was fitted with an alarm that sounded when opened. This environmental restriction had not been identified by the provider or its use reported to the Chief Inspector, as is required. The inspector also queried the arrangements regarding the storage of oxygen in the centre. This is discussed further in the Quality and safety section of this report.

There were three residents staying in the centre on the day of this inspection. The inspector had an opportunity to spend some time with all three residents at various times during the inspection. One resident had already left the centre to attend their day service by the time the inspector arrived. They attended their day service five days a week. Two other residents also attended day services three or four days a week. The fourth resident was supported to engage in activities during the day by members of the centre's staff team. This was reported to work well for them. Two staff supported two residents to go out later in the inspection, visiting a market on the outskirts of the city. Management advised the inspector that residents now had more opportunities to spend time in the local community as more members of the staff team were able to drive. Later the inspector saw activity records which indicated time spent in local cafés, parks, and shopping centres. Residents were also supported to go swimming and to access other amenities, such as a local hairdresser.

The residents living in this centre did not use speech to express themselves. From the time spent in their company it appeared to the inspector that residents were at ease and comfortable in the centre. They responded positively to staff interactions and appeared familiar with their daily routines, including those around mealtimes and leaving the centre. All staff interactions with residents, both observed and overheard, were kind and respectful. Staff demonstrated a good awareness of residents' assessed needs and it appeared that warm relationships had been developed.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. The inspector reviewed the feedback received from some residents' relatives as part of the annual

review process. This feedback was very positive, with one stating they felt that the centre gave 'the best of everything'. One respondent reported had never seen their relative so happy and well. Respondents reported that they were satisfied with the quality of care provided to residents and that their needs were met in the centre. The staff team were praised and described as fantastic, lovely, warm, and friendly. Staff's attention to detail and regular communication with family members was also referenced. The only areas highlighted for improvement through this feedback were the need for new flooring and possible better communication between the staff who worked on opposite shifts to each other. These points were followed up on the day of this inspection with management.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following two unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. Staff training and rosters were reviewed. The inspector also looked at a sample of residents' individual files. These included assessments completed and residents' personal development, healthcare and other support plans. Fire safety and medication management processes in the centre were also reviewed. These findings will be outlined in the remainder of this report.

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

While some areas of improvement were noted since the last inspection, findings indicated that the systems in place remained insufficient to ensure effective management and oversight of the service provided to residents living in this centre.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. Care and nursing staff reported to a nurse manager, who reported the person in charge, who reported to the person participating in management. There had been some changes to the management arrangements in the centre since the last inspection. The remit of the person in charge had changed and a nurse manager had returned to work in the centre two months prior to this inspection. As outlined in the opening section of this report further changes were planned. Meetings had been scheduled to prepare for this management transition. The inspector was also told that some of the incoming team knew some of the residents living in the centre from previous roles.

The inspector was informed that either the nurse manager or person in charge was

in the centre three days a week and outside of this were available to staff on the telephone throughout the working week. The provider had a system in place whereby a manager was contactable to the staff team at all times, including overnight and at weekends. The person in charge advised that they aimed to hold a staff meeting four times a year. The inspector reviewed minutes of meetings held in February and October 2023. The person in charge advised that handover meetings were held between staff weekly in the centre and that they also regularly attended these meetings. Despite these opportunities to meet with management and raise any concerns they may have about the quality and safety of the care and support provided to residents, as will be outlined in the next section of the report, management had not been informed of incidents where medicines were not administered to residents as prescribed.

A number of audits and checks were being completed on a regular basis in the centre. Areas monitored included medication management, personal care, protected mealtimes, cleaning, and practices associated with infection prevention and control (IPC). While there was some evidence of these audits identifying improvements that were needed, a review of the medication management, environmental, and cleaning audits completed in the centre indicated that they were not always effective. Areas observed to require cleaning during this inspection and a number of the required premises works had not been identified in the related audits. This was possibly as a result of all areas / rooms in the centre not being included in the templates used. None of the four medication management audits completed in the previous 12 months had identified any shortcomings to be addressed. As will be outlined in the next section of this report, this was not consistent with the findings of this inspection.

The provider had completed an annual review and twice per year unannounced visits to the centre, as required by the regulations. The most recent annual review was completed in March 2023 and involved consultation with residents and their representatives, as is required by the regulations. The feedback received at that time is referenced in the opening section of this report. Although this review included an action plan, no actions had been generated from the consultation with residents' representatives, despite this feedback highlighting areas where improvements were required. The inspector followed up on the issues raised and was informed of the actions taken to address them.

Unannounced visits had taken place in October 2022, May 2023 and again in November 2023. The purpose of these visits is to report on the safety and quality of care and support provided in the centre and to put a plan in place to address any concerns identified. Management had not yet received the report following the visit completed the week prior to this inspection. A review of the two previous reports indicated that while there was progress in areas, not all actions to address areas requiring improvement identified during these visits were being progressed or had been completed. A number of actions were repeated in consecutive reports. These included areas requiring maintenance, issues with fire doors closing fully, the need to revise the centre's contingency plan regarding any transmissible infections in the centre, the need for a risk assessment regarding the staffing levels when there were fewer than four residents in the centre, staff training gaps, and lack of progress in

achieving residents' personal goals. These remained outstanding on the day of this inspection. Some of the other findings documented in these reports were consistent with the inspector's findings during this inspection. These included the need for the safe storage of oxygen in the centre, improvements required to night-time simulation evacuation drills, and the noted absence of labels on some medicines administered in the centre. These findings indicated that the provider's management systems were not sufficient to address areas that the provider's representatives had identified as requiring improvement.

In a noted improvement since the last inspection, a training matrix was available for review regarding the staff working in this designated centre. A review of these records indicated that a number of staff required training in areas identified as mandatory in the regulations. These included fire safety, training in the management of behaviour that is challenging including de-escalation and intervention techniques, and infection prevention and control. The provider had outlined a number of other training topics as mandatory for staff working in this centre in the statement of purpose. These included manual handling and a human rights-based approach to health and social care. Records available indicated that not all staff had completed this training.

The inspector reviewed the centre's statement of purpose. It was noted that the version available in the centre was more recent than the one submitted to support the application to renew the registration of the centre. On review of this document with the person in charge, it was identified that some minor amendments were required to ensure all of the information was accurate. This was completed on the day and the inspector asked that this version be submitted to the Chief Inspector.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of this centre in line with requirements outlined in this regulation.

Judgment: Compliant

Registration Regulation 8 (1)

The provider had made an application to vary a condition of the registration of this centre in the form determined by the Chief Inspector.

Judgment: Compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The provider had paid the annual fee referenced in this regulation.

Judgment: Compliant

Regulation 15: Staffing

The staffing levels in the centre varied based on the number of residents staying at any one time. Due to residents' assessed needs there were two waking staff in the centre by night and one nurse on duty at all times. The inspector reviewed a sample of actual rosters and found that staffing in the centre was provided in line with the planned rosters, and as outlined in the statement of purpose. There were some staff vacancies and a number of other staff were on periods of extended leave. This shortfall was managed by the staff team and the use of agency staff as required. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The information available regarding staff training indicated that not all staff had recently completed the training identified as mandatory in the regulations. Some staff required training in fire safety, and in the management of behaviour that is challenging including de-escalation and intervention techniques. Staff also required training in infection prevention and control and hand hygiene. Due to the assessed needs of the residents living in the centre, the provider had identified that staff also required people moving and handling training. Records reviewed indicated that not all staff had current training in this area.

Judgment: Not compliant

Regulation 22: Insurance

The provider had ensured that there was a contract of insurance against injury to residents in place, as is required by this regulation.

Judgment: Compliant

Regulation 23: Governance and management

The findings of this inspection indicated that there were insufficient management systems in place to ensure a safe, consistent, and effectively monitored service was provided to residents in this centre.

An annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed. There was evidence that the action plans developed following these audits were not consistently implemented. There were a number of repeated findings in consecutive reports, for example, training gaps, lack of progress in supporting residents to achieve their goals, and to update the contingency plan to be implemented in the event of a suspected or confirmed transmissible infection. The inspector reviewed this plan and found that it had not been recently updated and contained outdated information in a number of sections.

Management and oversight systems required improvement. Findings of this inspection indicated that the audits completed in the centre were not effective in identifying areas where improvements were required. The environmental audit did not include all of the rooms in the centre. It was identified in this inspection that one of the rooms not included required maintenance to ensure it was kept in a good state of repair. In contrast to the findings of this inspection, audits regarding medication management practices had not identified any areas requiring improvements. Management also reported that they had not been made aware of incidents regarding medicines not being administered as prescribed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. Some revision was required to ensure that the information included was accurate and reflective of the arrangements in the centre. This was addressed before the end of the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

It was identified that not restrictive practices used in the centre had been notified to the Chief Inspector as is required by this regulation.

Judgment: Not compliant

Quality and safety

Residents appeared at ease and happy to live in this centre. There was evidence of increased access to, and time spent in, the community since the last inspection. Residents enjoyed positive relationships with staff and family members. However, it was found that significant improvements were required to ensure resident safety by meeting the requirements of the regulations regarding medication management and fire safety.

Contact with family members was important to the residents in the centre and this was supported by the staff team. Visitors were welcome and relationships were also maintained using telephone and video calls. Some residents regularly visited their family homes. Management advised that there was regular contact with family members.

The inspector reviewed a sample of the residents' assessments and personal plans. These provided information regarding residents' assessed needs and guidance on the support to be provided by staff. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and preferences, personal care, healthcare, and other person-specific needs such as mealtime support plans. A multidisciplinary review of each plan had been completed in September 2023.

Residents' healthcare needs were generally well met in the centre. Each resident had an annual healthcare assessment. From the records made available to the inspector it was difficult to determine when some residents had last been assessed and reviewed by a general practitioner, outside of out-of-hours medical services. There was evidence of regular review of healthcare needs by nursing staff and attendance at specialist consultant appointments, as required. Where a healthcare need had been identified a corresponding healthcare plan was in place. It was identified that there were two plans in place regarding the management of a health condition for one resident. These plans were not consistent with each other. It was also documented in one of these plans that all staff should be trained and familiar with the administration of a specific emergency medicine. Records reviewed indicated that all staff did not have this training, however there was always a nurse on duty in the centre. There was evidence of input from health and social care professionals such as speech and language therapists, dietitians, and physiotherapists. Residents who required them had recently reviewed recommendations and support plans regarding feeding, eating, drinking and swallowing. A summary document had been developed should a resident require a

hospital admission.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Personal development goals outlined what each resident wanted to achieve in the year. These goals were personal to the residents and reflected their interests. Some of these plans had been most recently developed in the weeks prior to this inspection. It was noted that some of the goals included were repeated from previous years. When reviewing previous goals it was difficult to determine what progress had been made, if any, in supporting residents to achieve them. For example, one resident had a goal in December 2022 to stay overnight in a hotel. 11 months later this had not taken place and there was no documented progress in place to achieve this goal.

The inspector reviewed the medication management processes in place in the centre with a staff member. A member of the management team was also present. As referenced previously in this report, the inspector had reviewed a number of medication management audits completed by a number of staff working in the centre. None of these had identified any areas requiring improvement. The number and seriousness of the inspector's findings in these areas resulted in the provider being issued an urgent action to outline how they would come into compliance with the requirements of this regulation.

The storage arrangements for medicines in the centre were inspected. The designated medication fridge could not be locked. This medication was therefore not stored securely, as is required by the regulations. It was noted that there were some medicines stored in a plastic bags and containers rather than their original boxes. These were not labelled. It was stated in the provider's policy that medications must only be administered from clearly labelled containers/pouches. The inspector saw that two of these tablets were broken. It was noted that a number of homeopathic items were also stored in the centre and administered to residents. One of these had not been closed properly and spilled when picked up by the inspector. These findings indicated that the storage of medicines in this centre required significant improvement.

The homeopathic items administered by staff to residents were not labelled or included on residents' prescriptions. They were included on medication administration records where it was indicated that they had been prescribed by a registered nurse prescriber. These practices were not consistent with the provider's policy.

Some PRN medicines (medicines to be used as the need arises) stored in the centre had passed their expiration date but remained stored with in-date medicines. The provider did have segregated, secure storage for medicines that were out of date or to be returned to the pharmacy, as is required by the regulations. When discussing the items stored in this container, staff advised that at times some residents may return from visits with family members and not all of their prescribed medicines may have been administered. They advised that these medicines may be then returned to the pharmacy. The inspector then asked if these incidents were documented or

considered from a safeguarding perspective and was advised that they were not. At the feedback meeting the person in charge advised that they had not been informed of these incidents. It was identified that there were no records maintained of medicines given to, or received from, family members when residents spent time away from the centre, although these records were maintained regarding the transfer of medicines to and from day services. There were also no records available regarding medicines received from the pharmacy.

When discussing the administration of medicines to residents, a staff member advised the inspector that at times they broke one tablet in two as due to its size and their assessed needs it may be difficult for the resident to swallow. This instruction was not documented on this resident's prescription chart, as is required by the provider's policy. This policy also outlines examples of medication errors / near misses and the procedures to be followed, including reporting and documentation requirements. Despite the findings of this inspection, the inspector was informed that there were no medication error records in this centre.

Controlled drugs were stored in the centre. The provider had ensured that the procedures outlined in provider's policy regarding the storage, counting and recording, and administration of these medicines were implemented in the centre. The inspector reviewed the prescription sheet regarding these medicines and noted that they were prescribed by a nurse prescriber. According to the provider's policy these controlled drugs could be prescribed by a registered nurse prescriber for pain relief in hospital, or for palliative care. As neither of these situations applied to this resident or designated centre, the provider was asked to provide assurances regarding these prescribing practices to the Chief Inspector. This request formed part of the urgent action plan.

Fire safety arrangements in the centre were also reviewed. The premises was provided with fire safety systems including a fire alarm, emergency lighting and fire extinguishers. Systems were in place to ensure these were maintained and regularly serviced. Staff were completing regular visual checks regarding fire safety, which included fire doors and escape routes. As referenced in the opening section of this report it was identified during this inspection that not all fire doors closed fully. As a result they would not be able to function as effective containment measures if required in the event of a fire. The records completed by staff indicated that this was a recurring issue in the centre. Management arranged for the fire doors to be addressed on the day of this inspection.

An illuminated sign indicated that the external door in the staff office was a fire exit. There were items blocking this exit on the day of the inspection. The emergency escape routes for the centre were not documented or on display. Given the size of the office and the furniture in place, it was not an accessible fire escape for the residents who lived in the centre.

Evacuation drills were taking place and were completed within timeframes assessed as safe by the provider. Although a drill involving all four residents in what was described as a night-time simulation had been completed in February 2023, it was not clear that residents were in bed at this time. Given the support required by

residents to transfer safely from their beds, this was an important consideration. This had also been flagged by representatives of the provider during an unannounced visit. There was evidence of reflection and learning following drills but this was not reflected in the fire procedure on display in the centre which was not specific to this centre or the residents living there. All four residents had a recently reviewed personal emergency evacuation plan (PEEP) to be implemented if required. It was noted that these plans did not include the number of staff or any evacuation aids required to support a resident to safely evacuate. Management committed to addressing these issues.

There were insufficient systems in place for the assessment, management and ongoing review of the risk associated with the storage of oxygen cylinders in the centre. The practices in place on the day of the inspection posed a risk to resident safety. The inspector observed one cylinder stored in the kitchen, a high risk area for fire that contains a number of heat sources. A second cylinder was stored outside, beside an external door that was a designated emergency exit. This cylinder was not stored in a way that protected it from the elements and was observed to be unclean and rusted. The person in charge arranged for the cylinder stored outside to be removed during the inspection.

Regulation 11: Visits

As was planned at the time of the last inspection, an additional room had been installed in the garden area to facilitate residents to receive visitors in a private area other than their bedrooms. This was accessible to residents, fully furnished and available for use.

Judgment: Compliant

Regulation 17: Premises

Improvements were noted in the condition of the premises since the last inspection. In general the centre was cleaner and some areas requiring maintenance had been addressed. However, it was apparent that some areas (for example some kitchen equipment, hand sanitiser bottles, and other items in the entrance hallway) were missed when cleaning was completed and there were a number of areas requiring maintenance (for example, damaged surfaces including the kitchen counter, flooring, and rusted bathroom fittings).

As referenced in the findings regarding Regulation 28, the staff office formed part of an escape route in the centre. The use of this area as an office indicated that the centre was not designed and laid out to meet the aims and objectives of the service, as is required by this regulation.

Judgment: Substantially compliant

Regulation 20: Information for residents

A residents' guide had been prepared in respect of the designated centre and recently reviewed. This document met the requirements of this regulation.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider did not have effective fire safety management systems in place in the centre.

As was found in the May 2022 inspection not all fire doors in the centre closed fully, including the door to the laundry, a high-risk area for fire. As a result they may not serve as effective containment measures if required in the event of a fire. Management arranged for these to be reviewed and addressed on the day of inspection.

The emergency evacuation routes were not documented in the centre. Illuminated signs in the building indicated that the external door from the staff office was a fire exit. The presence of office furniture and other items blocked this exit. This area was also very narrow and would be difficult for some residents to access due to their personal mobility equipment. The evacuation plan on display in the centre did not reflect learning from an evacuation drill completed in June 2023.

Evacuation drills were completed regularly and there was evidence of learning from these. There was a record of a drill completed in a night time scenario however this was completed at 17:00 and it was not clear from the information available if residents were supported to evacuate from their beds, as would be required in the case of a fire overnight.

Although each resident had a personal emergency evacuation plan (PEEP) which had been reviewed since the last inspection, these did not contain sufficient information to guide staff if required. For example, the number of staff or any specialist equipment required to safely evacuate a resident was not documented.

The arrangements regarding the storage of oxygen in the centre also required review.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Due to the findings regarding medication management in the centre, an urgent action was issued to the provider.

It was identified that the provider's policies regarding medications were not consistently implemented in the centre. Findings included that some medicines were not stored securely or in line with the provider's policy, that medicines were at times administered in a form not outlined on the available prescription, and that not all products administered were included on residents' prescriptions. It was also identified that records of medication errors were not kept in the centre. The findings of this inspection indicated that significant improvements were required to ensure there were appropriate, safe and suitable practices relating to the receipt, storage, disposal and administration of medicines in this centre. The Chief Inspector also sought assurances from the provider regarding the prescribing of controlled drugs to a resident.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs had been completed for each resident. It was noted that not all healthcare assessments had been completed in full. In addition it was noted that there were two inconsistent management plans in place for the treatment of a specific medical condition for one resident. Management committed to addressing this. Each resident had a personal plan which was reviewed at least annually. Improvements were required in the development and review of residents' personal development goals. It was noted that some residents' goals were repeated in consecutive years. It was also difficult to determine what progress had been made, if any, in supporting residents to achieve their goals.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were generally well met in the centre. The finding regarding two inconsistent plans being available regarding the same medical condition are reflected in the findings regarding Regulation 5.

Judgment: Compliant

Regulation 7: Positive behavioural support

None of the residents who lived in this centre had been assessed as requiring a behaviour support plan. The findings regarding training are reflected in Regulation 16.

Not all restrictive practices used in the centre had been recognised. Therefore they were not subject to the provider's policy and procedures. These included a locked wardrobe and an alarm that sounded when the external door to the activity room was opened.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The practice of routinely checking residents overnight, as referenced in the last inspection report, had been reviewed. Night-time checks were now only completed where they had been assessed as necessary. There was evidence of ongoing work with speech and language therapists to make meetings and consultation more accessible and meaningful to residents.

It was identified that a cupboard used to store personal information regarding residents was not locked. At the time of the May 2022 inspection, the inspector highlighted to staff that a photograph of a former resident remained on display in one resident's wardrobe. This was observed to be still in place during this inspection. It was removed by management on this occasion. These findings indicated that improvement was required regarding respect for residents' privacy and dignity in relation to their personal and living space and personal information.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 8 (1)	Compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 16 OSV-0003292

Inspection ID: MON-0040870

Date of inspection: 15/11/2023

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC will update the training matrix and identified training gaps. Completed 30.01.2024 • Fire training to be completed for 3 staff. Training has been requested. To be completed by 31.03.2024 • Safety Intervention training has been identified as not a required training for this designated centre. However, if in the future this is required through an updated risk assessment the PIC will arrange training. Positive Behavior Support training has been identified to be completed for 3 staff. Training is booked for the following dates 12/03/2024 To be completed by 12/03/2024 • Infection prevention and control refresher training has been identified to be completed by all staff. To be completed by 31.03.2024 • Hand hygiene refresher training has been identified to be completed for all staff. To be completed by 31.03.2024 • Manual Handling training is required for 1 Staff. Training has been booked for the following dates 31.03.2024 To be completed by 31.03.2024	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • To ensure effective Governance and Management of the center in regard to the	

oversight of the actions from the six monthly and annual review a tracker online compliance has been created. This electronic tracker will be updated monthly or as compliance is achieved. Training matrix is updated by the PIC to ensure training is planned in advance and arranged by PIC. Staff training will be an item on agenda to be reviewed and discussed with PPIM. Completed on 13.02.2024

- The PIC through staff meetings with keyworkers will discuss residents' goals, outcomes and progress. To be completed by 31.03.24
- The contingency plan is being reviewed and updated. To be completed by 16.02.2024
- The environmental audit is reviewed and all rooms in the designated centre are included in the audit. This audit is on an annual schedule which the PIC will have oversight and review. Completed on 12.02.2024
- Daily identified maintenance will be submitted to the PEMAC system , logged and sign when completed with oversight and follow up PIC.
- An internal medication audit has been completed by the Assistant Director of Nursing. Actions identified have being actioned. An external medication audit from dispensing pharmacy has been completed on 07/02/2024. Any identified medication errors will be inputted through the national NIMS system. NIMS will be discussed with all staff team at quarterly staff safety meeting. To be completed on 08.03.2024.
- The PIC, CNM1 and PPIM's oversight and governance of the Designated Centre will be demonstrated through visits to the centre . Guidance to staff through performance management, maintaining training and further development. Oversight of review of paperwork, audits, updating 6 monthly, annual report and HIQA compliance incorporating general quality and safety within the centtre.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

- A review of all restrictive practices within the Designated Centre has been undertaken by the PIC and staff team with involvement of the MDT team if required. Oversight will be supported by the PPIM. The restrictive practice log has been be updated. Completed by 13.02.2024
- Restrictive practice will be submitted HIQA in the next quarterly returns will be submitted by for Q4 2023 31.01.2024 and Q1 2024 30.04.2024
- At the quarterly Quality and Safety Meeting restrictive practice within the Designated Centre will be a topic and review and discussion. To be completed 08.03.2024

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Counter where surface has been damaged has been ordered 30.04.2024
• The cleaning rota has been updated to include all areas within the residence. completed by 13.02.2024
• The Facilities manager has identified flooring which needs replacing. Quote will be obtained for replacement of flooring. Flooring replacement to be completed by 30.09.2024
• A PEMAC request has been submitted to update rusted fittings in bathroom. To be completed by 31.03.24
• Painting of entire house and 2 front doors commenced on 13.02.2024 to be completed by 29.02.2024
• Oxygen tank moved from kitchen 12.02.2024
• Office area reviewed by Gendist as an escape route. Same has to remain in floor plans as escape route. See engineers report attached. 31.03.2024
• Automatic door release fitted to Office door. 12.02.2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• An evacuation floor plan has been reviewed by the facilities Manager and relevant bodies to discuss this evacuation door and its need. Same completed 13.02.2024
• An updated evacuation plan has been reviewed to identify all emergency routes with relevant signage. Awaiting Fire escape route for wall. 29.02.2024
• Fire Drill documentation has been reviewed by the PIC and actions post learning following each fire drill will also form the part of the unit safety meeting on 08.03.2024
• Each resident has been assessed according to their required specialist equipment in the event of an evacuation. PEEPs are updated according to reflect individuals needs. Completed on 12.02.2024
• Oxygen storage area reviewed by Facilities manager. Same moved and inserted into locked cage. Completed 06.02.2024
• A night time evacuation drill was simulated and learning documented. Completed on 14.02.2024

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Please see as per Provider Assurance report submitted:

1. Site Specific Pharmacy and Medication Management protocol has been devised by PIC and CNM1. This protocol addresses ordering, prescribing, storing and disposal of medication with corresponding paperwork available to complete same. An error log can also be found in this protocol to record any errors with pharmacy supply or paperwork. All emails to pharmacy will be printed and retained onsite and all calls will be recorded going forward as part of site-specific protocol. Completed on 20.11.2023
2. The protocol will be read and signed by all staff nurses in Cork City North 16. Completed on 27.11.2023
3. All PRN medications have been reviewed completed on 22.11.23. Any out of date/unused medications have been returned to pharmacy using the protocol for returning goods as per local protocol and organisational policy. Completed by 25/11/2023.
4. A medication management audit was carried out by Assistant Director of Nursing. Completed on 20/11/2023.
5. Identified actions from medication management audit and completed by 30.11.2023 Person in Charge has requested dispensing Pharmacy to carry out a pharmacy audit in the Designated Centre. Completed on 07.02.24
6. The lock on the Medication fridge has been repaired and key is available on site.
7. Under the Misuse of Drugs Regulations (2017) Schedule 8 as outlined in Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority (4th Edition) Appendix 2 , and as outlined in the Providers Policy (Policy, Guidelines & Protocols to Support Nurse Prescribing 2022) the nurse prescriber may prescribe controlled drugs within schedules 2 and 3.
8. The PIC has ensured that Controlled Drugs have been reviewed and that unused controlled drugs have been returned to the pharmacy as per local protocol and organisational policy. Completed on 23.11.2023.
9. Residents Kardex have been reviewed to ensure that prescribed medication is in accordance with the residents assessed needs. Completed on 23.11.2023
10. The provider is currently liaising with residents' medical practitioners and pharmacy provider in an attempt to resolve the issue pertaining to the labelling of prescribed, homeopathic and alternative remedies. Update letters received from GP services and consultants confirming use of homeopathic and alternative remedies. However, labels cannot be provided by the pharmacy but are written up in residents by GP / nurse prescriber. This has is being held at organisational level. Completed on 23.11.2023

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• An audit of personal plans has been completed.
• All health care assessments and health action plans will be reviewed and updated to include all identified health actions relevant to each residents assessed need. To be completed by 31.03.2024

• Residents PCP goals will be reviewed with each resident / keyworker to ensure variety of goal opportunities. A stepped approach to achievement will clearly identify each residents' goals. To be completed by 31.03.2024

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The PIC will review individuals need for requirement of a behaviour support plan. To be completed 14.02.2024
• On date of inspection broken lock on wardrobe replaced. This is now not a restriction for the resident. Completed on 15.11.2023
• The exit alarm on activity room external door has been removed. Completed by 22.11.2023.
• All wardrobes locks and keys taken from wardrobes in bedrooms. Completed on 14.02.2024

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A cupboard used to store personal information now has a lock. Completed on 22.11.2023
• A person's picture who no longer resides in the centre was removed on day of inspection from another residents' room. Completed on 22.11.2023

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/03/2024
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	30/09/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	30/09/2024

	state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	29/02/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/03/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	08/03/2024
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	08/03/2024
Regulation 28(2)(b)(i)	The registered provider shall make adequate	Not Compliant	Orange	29/02/2024

	arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	08/03/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	08/03/2024
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Red	24/11/2023
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration	Not Compliant	Red	24/11/2023

	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 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	24/11/2023
Regulation 29(4)(d)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal	Not Compliant	Red	24/11/2023

	and administration of medicines to ensure that storage and disposal of out of date. unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988 (S.I. No. 328 of 1988), as amended.			
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	30/01/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently	Substantially Compliant	Yellow	31/03/2024

	as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/03/2024
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/03/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures	Substantially Compliant	Yellow	14/02/2024

	are applied in accordance with national policy and evidence based practice.			
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	30/11/2023