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 South 1
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	11 July 2023
Centre ID:	OSV-0003695
Fieldwork ID:	MON-0039228

About the designated centre

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

Cork City South 1 consistent of three large detached two-storey houses located on the outskirts of a city. Combined the three houses can support up to 25 residents. The houses mainly provide a full-time residential support for residents with intellectual disabilities and autism of both genders, over the age of 18 but can also provide some respite. Individual bedrooms are available for all residents in each house and other facilities in the houses include bathrooms, sitting rooms, dining rooms and kitchens. Support to residents is provided by the person in charge, house parents, care assistants and staff nurses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	22

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 11 July 2023	10:20hrs to 20:30hrs	Conor Dennehy	Lead
Tuesday 11 July 2023	10:20hrs to 18:00hrs	Laura O'Sullivan	Support

What residents told us and what inspectors observed

Generally positive feedback was provided from residents although one resident did raise an issue relating to the evening time. Staff were very pleasant towards residents and efforts were made to make all houses homelike. However, two houses did appear dated with the provider intending to transition residents in these houses elsewhere in the future.

This centre was made up of three different houses all of which provided mostly residential care but some respite care also. Two of the houses were based side-by-side while the third house was located 15 minutes' drive away. On the day of this inspection 22 residents were present in the three houses. All three houses were visited by at least one of the inspectors which gave them an opportunity to meet residents and staff while also being able to observe residents in their environments and in their interactions with staff. During the course of the inspection a total of 20 residents were met by the inspectors.

Inspectors commenced the inspection by first going to the two houses that were located side-by-side. Most of the residents who lived in these houses had already gone to day services operated by the same provider in a different location. Three residents did remain though in one house and shortly after the inspection commenced, these residents left their house with staff to go for a drive before returning later in the afternoon. As these houses were largely unoccupied during the initial stages of the inspection, inspectors focused upon assessing documentation and reviewing the premises provided by these houses.

It was observed that both houses were similar in their general layout and size although one of the houses had nine individual resident bedrooms for residents while the other had eight. The two houses were generally clean on the day of inspection although in two bathrooms in one house an inspector did observe some clear patches of mould on the ceiling. Efforts had been made to make both houses homely. For example, communal areas such as sitting rooms were well furnished with couches, televisions and framed resident photographs. It was seen though that in areas of these houses there was an abundance of posters and signs on display which detracted from the homelike feel.

In addition, it was apparent that both houses were dated in aspects of their appearance. For example, some of the flooring in communal areas and some residents' bedrooms were older in their general feel and look. The provider had previously communicated that it was their intention to transition the residents living in these houses to smaller community based houses as part of a decongregation plan. It was suggested that this could take two years to accomplish and that residents and their families had been informed about this. It was unclear at the time of this inspection if this transition would take place within the time frame initially suggested.

As the day progressed residents returned to both of these houses from their drives or their day services. This gave inspectors an opportunity to speak to residents individually or as a group. In one of the houses, an inspector met seven residents who provided positive feedback on life in the centre while also speaking highly of the staff supporting them. Some of the residents in this house told the inspector how they had been able to choose whether or not to go to day services and of the positive change that this had brought about for them. One particular resident talked about an upcoming holiday and showed the inspector a diary of upcoming events which was maintained with staff support. While in this house the inspector was shown two residents' bedrooms with one resident highlighting to the inspector their favourite movie posters and the other showing their family photos.

In the other house, an inspector met seven of the residents together in the sitting room. While some of the residents present spoke more than others, the general feedback provided by the group was very positive. This included residents praising the staff and indicating that they felt safe while in the house. Some residents also talked about some of the activities they did away from the house with staff support such as going to local shops, visiting nearby towns and going for meals out. None of these residents raised any concerns during this group discussion but the inspector told any of the residents to let him know if they wanted to speak on a one-to-one basis.

None of the residents requested this but three residents did offer to show the inspector their bedrooms. It was observed that these residents' bedrooms were personalised to the individual residents and all three of the residents told the inspector that they liked their bedrooms. While viewing these bedrooms, two of the residents mentioned to the inspector that in two years' time they would be moving to a new smaller house in another location having been told this by management of the centre. When asked by the inspector, both residents indicated that they were looking forward to this move.

After finishing in the two side-by-side houses, one of the inspectors visited the third house of the centre. Upon his arrival there four residents were present with a staff member supporting them. Another four residents were away from the house at the time having gone to a shopping centre with another staff member. The inspector met three of the residents as they were sat together in one of the house's sitting rooms. The inspector sat with residents, initially in the presence of the staff member, and all three indicated that they liked being in this house. They also mentioned how they would be on holidays next week.

When asked by the inspector what they would do during their holidays, two of the residents indicated that they would be going to stay with some family while the third appeared to suggest that they would be doing nothing. The resident appeared very happy with this. One of these residents did tell the inspector though that they would like to see their friends more and to do a knitting class in the evenings. The resident said that they could not currently do either. Aside from this though this resident generally spoke quite positively and engaged jovially with the inspector when he said he was from Kerry with the resident informing him that Cork would always beat

Kerry in GAA, the inspector jovially did not agree with this.

While in this house the inspector reviewed the premises provided and noted that the house was generally presented in a clean and well maintained manner. It was noted though that one door handle was broken. Despite this it was observed that one particular bathroom in the house was noticeably cleaner than it had been during a previous inspection in October 2022. Before the inspector left this house he met three of the residents who had returned from their outing to the shopping centre. These three residents greeted the inspector and appeared quite content. One of the residents showed the inspector a newspaper with a photo of their brother in it. The inspector was informed that the resident's brother had won a gold medal in the recent Special Olympics World Games.

Throughout this inspection, in all three houses residents appeared comfortable in the presence of staff members who engaged pleasantly with residents throughout. For example, in one house a resident happily showed the person in charge a wedding invite they had received while in another house a staff member was seen to warmly greet residents as they came on shift. Person-centred support was being given to residents who may have been going through any health concerns. It was observed though that in one house of the centre, staff on duty there wore scrubs while in the house supporting residents. It was unclear why this being done as this house was not a clinical setting and this was not being done in the other two houses. It was observed though that when leaving this house to support residents to go on outings, these staff would change out of their scrubs into regular clothes.

When the residents and staff returned to the house after their outings, the staff then changed back into their scrubs. On one particular occasion, a resident living in this house indicated they wanted to go for a walk to a staff member. However, the resident had to wait a few minutes before they could go on their walk as they had to wait for the staff member to change out of their scrubs and into regular clothes. In the same house it was also highlighted that there was hourly checks done for all residents at night. This had the potential to impact residents' privacy and there was no rationale given for such checks nor was there any evidence of consultation with residents about these checks.

In summary, efforts had been made to make all houses homely although two houses did appear dated while posters in some communal areas detracted from the homelike feel. Overall, while one resident did raise an issues around the evening time, the feedback from residents in all three houses was broadly positive. The residents appeared comfortable in the presence of staff members on duty with residents also speaking positively of the staff.

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.

Capacity and capability

While there had been some improvement from previous inspection, the overall governance and monitoring of the centre continued to need improvement. Regulatory actions were also identified regarding staffing, complaints and the submission of notifications.

This centre is run by COPE Foundation. Due to concerns in relation to Regulation 23 Governance and Management, Regulation 15 Staffing, Regulation 16 Training and development, Regulation 5 Individualised assessments and personal plan and Regulation 9 Residents' rights, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in October 2022 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan the provider has provided an action plan to the Chief Inspector highlighting the steps that the provider will take to improve compliance in the provider's registered centres. These regulations were reviewed on this inspection and this inspection report will outline the findings found on inspection.

Previous concerns had been identified for this centre relating to the impact that one resident was having on the peers they lived with in one of the houses that made up this centre. This contributed to there being high levels of non-compliance identified during previous inspection of this centre in October 2021, July 2022 and October 2022 as conducted by the Chief Inspector. During such inspections particular concerns were also identified regarding the overall governance and management of the centre. In response to the October 2022 inspection the provider submitted a compliance plan outlining the action they would take to come achieve compliance and to ensure all residents were appropriately supported. Amongst these actions it was indicated that one resident of this centre would transition to another designated centre operated by the same provider.

This transition took place early in 2023 and during the current inspection it was found that this had brought some positive changes. For example, safeguarding concerns in one house of the centre had noticeably reduced. It was also noted that a complaint made by one resident prior to the October 2022 inspection about the impact a peer was having on them, had been closed since the transition had taken place. The record of this complaint indicated that the resident was satisfied with the outcome. However, during the current inspection it was indicated to an inspector that residents in another house had been regularly complaining about not able to do activities away from the house in the evening. In notes of a recent residents' meeting this was described as a "major complaint". Despite the inspector was informed that no complaint about such matters was recorded in the house's complaints log.

This did not provide assurances that residents were being made aware of the provider's complaints processes nor that they were assisted to understand the

complaints process. This was highlighted during the inspection and the day following inspection it was indicated that a retrospective complaint had been made on behalf of the involved residents. These residents' abilities to engage in external activities was significantly impacted by the staff arrangements that were in place in that house. For much of 2023, only one staff member was on duty in that house in the evenings who could be supporting up to eight residents. Such staffing arrangements contributed to a risk around staff being escalated to senior management of the provider in recent months.

An inspector reviewed documentation related to this escalated risk and noted that, aside from the house where residents complained, staffing concerns affecting the other two houses of the centre were also highlighted. Inspectors were informed that this escalated risk remained open but it was seen that in recent weeks staffing arrangements had improved and additional staff shifts were being provided, although not always. The additional staff had a positive impact and it was highlighted that in the house where residents had complained about this matter, a second staff had been provided to the centre to support external activities. When one of the inspectors visited this house, it was noted that four of the eight residents present in the house on the day of inspection were initially away from the house having gone to a shopping centre with the second staff member.

The documentation around the escalated staffing risk also referenced a concern around the changing needs of residents. Under the regulations staffing in a centre must be in accordance with the needs of residents and on this inspection there was evidence that the needs of some residents were increasing, particularly in one house. Given such increasing needs, it would be important that the provider would monitor such needs to ensure that the designated centre was appropriate to residents' needs. However, as with the previous inspections of this centre, the current inspection also found that improvement was required regarding the overall monitoring and governance of the centre. Concerns around the governance arrangements for the centre were also identified in the most recent annual review of the centre completed by the provider in November 2022 and the most recent provider unannounced visit to the centre in February 2023.

Under the regulations, such provider unannounced visits must be done every 6 months but the February 2023 visit was the first such visit completed since June 2022. A report of the February 2023 visit was read by an inspector and it was noted that it did identify areas for improvement and included some similar findings to this inspection by the Chief Inspector. Despite this, the current inspection identified various regulatory actions including in a number of the same regulations where improvement had been identified during previous inspections. This did not provide assurance that all known matters affecting the quality and safety of care and supported provided to residents were being responded to appropriately. In addition, there was evidence that other monitoring systems were not effective at identifying issues.

For example, in one house it was seen that an audit schedule was not being adhered while a fire safety audit for that house conducted in June 2023 identified no areas for concern. As will be discussed further in the section below, improvement

was identified during this inspection regarding fire safety in this and the other two houses. Aside from such matters, it was also found during this inspection that some required notifications had not been submitted to the Chief Inspector in a timely manner. Under the regulations certain specified events, which involve residents, must be notified to the Chief Inspector within 3 working days. On the current inspection it was identified that one such event had not been notified as required although the person in charge did submit this retrospectively on the day of inspection. It was also identified that the provider had not notified the Chief Inspector in a timely manner after the return of the person in charge from a period of absence.

Regulation 15: Staffing

There was an escalated risk open to this centre relating to staffing. Staffing arrangements had impacted residents' abilities to engage in activities away from the centre but it was seen that in recent weeks staffing arrangements had improved and additional staff shifts were being provided, although not always. Documentation relating to the escalated risk also referenced a concern around the changing needs of residents and there was clear indications that the needs of some residents were increasing.

Judgment: Not compliant

Regulation 16: Training and staff development

Records provided indicated that staff working in this centre had completed training in areas such as fire safety, safeguarding and positive behaviour support.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not carried out the six monthly provider unannounced visit to the centre between June 2022 and February 2023. The annual review for the centre completed in November 2022 did not assess the centre against relevant national standards. Audit schedules were not being consistently followed as part of a systematic monitoring of the centre while audits completed did not always identify relevant issues. This contributed to there being a number of regulatory actions on this inspection including in regulations which had been identified as needing improvement on previous inspection. The governance arrangements for the centre

continued to require improvement.

Judgment: Not compliant

Regulation 31: Notification of incidents

A specific event involving a resident had not been notified to the Chief Inspector within 3 working days as required.

Judgment: Not compliant

Regulation 32: Notification of periods when the person in charge is absent

The return of the person in charge from a period of absence had not been notified to the Chief Inspector within 3 working days as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

Residents in one house had been regularly complaining about not able to do activities away from the house in the evening. This was described as a "major complaint" in notes of a recent resident meeting. However, no complaint about such matters was recorded in the house's complaints log. This did not provide assurances that residents were being made aware of the provider's complaints processes nor that they were assisted to understand the complaints process.

Judgment: Not compliant

Quality and safety

Safeguarding had improved since previous inspections. This had a positive impact on residents' rights but during this inspection a number of instances were identified which did adversely impact on residents' rights. Person-centred planning, fire safety and infection prevention and control (IPC) were also identified as areas needing improvement.

Previous inspections had raised safeguarding in one house related to the presentation of one particular resident. The presentation of this resident also adversely impacted the rights of the other residents in this house as was noted in a previous compatibility assessment completed. The relevant resident had since transitioned to another centre operated by the provider. This had a positive impact on the remaining residents in this house with there being a noted reduction in safeguarding incidents since this transition. This also enabled the remaining residents to have more choice and control over their daily lives when in the house. The October 2022 inspection had also identified that private personal information related to residents was seen to be on display in a communal area of the same house while in another house residents meetings to consult with residents and give them information were not happening. The current inspection found improvement in both of these areas.

For example, no private personal information was seen on display in communal areas of the three houses visited by inspectors. Monthly residents' meeting were also happening in all three houses in addition to weekly planning meetings with residents that had been introduced in recent times. It was seen though that some notes of these weekly meetings indicted that personal information for individual residents was discussed during these communal meetings. Some of the content of certain residents' meetings were noted to be repetitive while, based on the notes provided there was a noticeable difference in the information being given to residents in one house compared to another. Such residents meetings are a way to consult with residents and it also important that residents are consulted in relation to the running of the centre.

Such consultation was aimed to be achieved through a process of person-centred planning which was intended to involve residents to identify meaningful goals for them to achieve. Inspectors reviewed a sample of person-centred planning documents for residents but noted in some that it was not always indicated if residents were consulted or not during this process. In addition, it was observed that some goals identified for residents were not individual to residents while records reviewed did not indicate how goals were to be achieved or if they have been progressed. From reviewing other documentation and from speaking with staff and residents, there was indications that residents were being supported to be achieve some of these goals which was positive. However, for other residents some goals had not been progressed despite being identified in August 2022 with this contributed to by staffing arrangements in place.

For example, one resident had a goal to go to the beach and it an inspector was informed that this had not been done due to the staffing arrangements in one house. The staffing arrangements in this house had limited residents' ability to take part in external activities which they had complained about as referenced earlier in this report. A staff member spoken with did indicated though that a second staff was not being provided to the house which would make it easier for residents' person-centred planning goals to be achieved going forward. Aside from the residents that had goals identified, it was identified though during this inspection that three residents had not had person-centred planning processes completed within the last 12 months. One of these residents last participated in such a process

in 2019 while the other two residents had being living in one house of the centre for over six months at the time of this inspection having been newly admitted there since the October 2022 inspection.

In accordance with the regulations, any resident must have a comprehensive assessment of their needs completed before their admission to a designated centre. However, for one of the two residents who commenced living in one house over six months ago, no such assessment had been completed. As such the resident's individualised personal plan was not informed by this assessment with their personal plan seen to be brief in its contents. One resident who availed of respite in another of the house was also seen to have a brief personal plan which was highlighted to the person in charge who indicated that more information would usually be provided for such respite users. Inspectors reviewed a sample of residents' personal plans in the three house and did note that they provided clear updated guidance in some areas relating to residents' assessed needs.

Despite this though, in one resident's personal plan it was seen that there was inconsistent information around the resident's diagnosis of dementia while some inconsistencies were also seen for some health assessments and health care plans. For another resident a specific health care plan around foot care indicated that the resident was to receive chiropody appointments every 6 to 8 weeks but an adjoining appointment log had no entries. This was queried with the person in charge who suggested that such appointments had happened with the chiropodist calling to the house where the resident lived. Other residents who lived in the same house and also required the support of a chiropodist were recorded as being regularly reviewed by a chiropodist during 2023.

Aside from such matters, all three houses that made up this centre had been provided with fire safety systems including fire alarms, emergency lighting and fire extinguishers. The houses had also been provided with fire doors which are important in preventing the spread of fire and smoke while providing for a protected evacuation route. Despite this in all three houses, inspectors observed issues with these doors which could impact their effectiveness. These included some fire doors being wedged open, some fire doors having noticeable gaps under them, one fire door missing part of its internal strip and one fire door not closing fully under its own weight. Improvement was also required regarding fire drills which are important to ensure that there was a familiarity around what to do in the event of a fire evacuation and to provide assurance that all residents can be safely evacuated.

Such fire drills had been done in all three houses since the October 2022 inspection but the records of some these drills contained limited details. In one house though the records available indicated that all fire drills conducted since February 2022 had only involved a maximum of six residents even though up to eight residents could be present in the centre. In the other two houses inspectors identified that fire drills had not been conducted to reflect a night-time evacuation when residents would be in bed and there would only been minimal staffing on duty. Residents did have personal emergency evacuation plans (PEEPs) in place outlining the supports they needed to evacuate but it was seen that one resident's PEEP did not reflect the outcome of some recent fire drills. It was also seen that an overall fire evacuation

plan for one house referred to a former resident.

Internal staff checks on fire safety were being carried out in the three houses but inspectors did observe some gaps in such records in two houses. Cleaning records were also in place for both of these two houses to confirm that scheduled daily cleaning was being completed. However, in one of the houses an inspector noted a number of gaps in these cleaning records on certain days of the week. In the third house, it was seen that additional external cleaning support had been provided to the house since the October 2022 inspection although it was indicated by a staff member in this house that they did not follow a cleaning schedule while it was unclear if the external cleaner followed one either. No cleaning records for this house were provided also even though in the compliance plan response for the October 2022 inspection it had been indicated that all houses would have cleaning schedules and cleaning records. It was seen though that generally the houses in this centre were clean particularly one of the bathrooms in one house which was noticeably unclean during the previous inspection.

The person in charge also outlined how they were seeking to get additional cleaning support for two of the houses. Effective and consistent cleaning is a key part of IPC practices. To support such practices it also important that staff have up-to-date knowledge and guidance on such matters. Information provided following this inspection indicated that all staff had completed relevant IPC training. However, in one house an inspector could not locate relevant IPC or COVID-19 guidance documents on the day of inspection. It was subsequently indicated the day following this inspection that a relevant IPC folder had since been located but that some of its contents required review or updating. The houses of this centre were noted to have supplies of hand sanitiser and personal protective equipment such as face masks and gowns. In one house though it was seen that some gowns had passed their stated validity period.

Regulation 13: General welfare and development

While there were gaps in some activity records reviewed, residents spoken with in two houses indicated that they did activities away from their houses such as going to shops and eating out with one house having a folders of photos of activities that residents did. However, in the other house residents had not been able to consistently engage in external activities. While this had improved in recent weeks with additional staffing, one resident told the inspector that they were not currently able to see their friends more often and to do a knitting course in the evening. One resident leaving the centre to go for a walk was delayed by a staff member having to change out of scrubs.

Judgment: Substantially compliant

Regulation 17: Premises

While all three houses were well-presented in areas, in two houses it was seen that they were dated in their look and feel. Two bathrooms in one house were seen to have patches of mould present.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Some risk assessments were seen relating to an individual resident which had not reviewed in over 12 months and required updating to reflect recent developments.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Some gowns in one house had passed their stated validity period. In one of the houses there were a number of gaps in cleaning records on certain days of the week. Based on the information provided inspectors were not assured that cleaning records and cleaning schedules were in place for one house. On the day of inspection relevant IPC or COVID-19 guidance documents could not be located in one house. While it was subsequently indicated that a relevant IPC folder had since been located, some of its contents required review or updating.

Judgment: Not compliant

Regulation 28: Fire precautions

In all three houses, inspectors observed issues with the fire doors provided which could impact their effectiveness. Fire drills carried out did not involve the maximum number of residents that could be in one house or were not conducted to reflect a night-time evacuation when residents would be in bed and there would only be minimal staffing on duty. One resident's PEEP did not reflect the outcome of some recent fire drills and an overall fire evacuation plan for one house referred to a former resident. Some gaps in internal fire safety checks were seen in two houses.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of need had not been completed for one resident who had been living in the centre for over six months. Some residents' personal plans were limited in their guidance. Person-centred planning goals were not always progressed. Some residents had not participated in a person-centred planning process while for some residents it was not clear if they had been consulted in such a process. There was inconsistent information in one resident's personal plan around their diagnosis of dementia while there was some inconsistencies for some health assessments and health care plans.

Judgment: Not compliant

Regulation 6: Health care

One resident was to be reviewed by a chiropodist every six to eight weeks but there was no record of the resident receiving such a review in 2023.

Judgment: Substantially compliant

Regulation 8: Protection

While residents had intimate personal care plans in place, there was inconsistency in the supports required in this area within some residents' overall personal plans. For example, supports set out in health action plans were not consistently reflected in residents' intimate care plans

Judgment: Substantially compliant

Regulation 9: Residents' rights

In one house hourly checks on residents were being performed at night without a clear rationale or evidence of consultation with residents. Personal information relating to individual residents was discussed during communal meetings. Some of the contents of certain residents' meetings were noted to be repetitive while there was a noticeable difference in the information being given to residents in one house compared to another. Residents in one house were not consulted in advance of two residents moving into that house although it was noted that there was particularly

circumstances related to these residents' admission to the house.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City South 1 OSV-0003695

Inspection ID: MON-0039228

Date of inspection: 11/07/2023

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The registered provider is committed to ensuring that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the SOP, layout of the Centre and in line with the current funding allocation. • Staffing in CCS1 was discussed at the registered providers allocations meeting and it was agreed that a specific part time role would be advertised to support residents in a person centred way across evenings/ weekends to engage in activities of their choice. • The Provider has commenced a decongregation plan for CCS1. A further review of skill mix and staffing resources is part of this process. When this review is completed, and if additional resources are required, a business case will be submitted to the HSE for additional funding. • The current PIC is responsible for 2 designated centres. The provider has already submitted a business case to the HSE for an additional funding for an additional PIC to enhance governance and management for all regulations including regulation 15. **The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations**	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The provider will ensure that 6 monthly provider unannounced visits will take place every 6 months as per regulation. • The Provider will ensure that internal auditors will access the Centre against relevant	

National Standards as part of future annual reviews.

• To improve monitoring and governance systems, the PIC and PPIM will meet 1;1 on a fortnightly basis at the Designated Centre to review progress, and if barriers are presenting how can they be resolved.

• The registered provider has a HIQA and internal audit action plan dashboard in place that is updated on a regular basis by PIC, and jointly reviewed by the PIC and PPIM at 1:1 manager meetings.

• The register provider has access to the dashboard and they can view at any stage to ensure the Centre is being effectively monitored.

• Dashboard is also reviewed at COO and PPIM 1:1 monthly meeting and where progress, and any barriers are discussed.

• This oversight tool is new to the designated centre and enables the staff, PIC, PPIM and the provider increased visibility to monitor actioning of tasks to increase regulatory compliance or barriers to tasks which inhibit increasing regulatory compliance.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• This specific event involving a resident was notified to the Chief Inspector retrospectively on the day of inspection on the 11th July.

• The PIC will ensure that systems are in place for the timely notification of incidents as per regulatory requirements.

Regulation 32: Notification of periods when the person in charge is absent	Not Compliant

Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent:
• The Registered Provider will ensure that systems are in place to ensure timely notifications as per regulatory requirements.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC did submit this complaint retrospectively on 12th July.

• The PIC will ensure that all residents are made aware and assisted to understand the

providers complaints process, this will be facilitated by including the complaints process on the agenda in the monthly advocacy forum.

Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: • Relief staff have come through recruitment and are available to ensure that residents are able to consistently engage in external activities of their choosing in the evenings. • A community mapping exercise will be completed by keyworkers and residents to explore options / external activities that may be available in the resident's community and that may be in line with individual residents wishes. Furthermore, natural supports would be explored such as families, volunteers and people who would already be involved in such activities to possibly support individual residents to take part in external activities/community groups. • The PIC will address staff dress code as part of the staff meetings.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The registered provider shall ensure that the premises of the designated center are of sound construction and kept in a good state of repair externally and internally. • The PIC, PPIM and Facility manager will carry out a walk through CCS1 to agree works and put a schedule in place for completion.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • All risk assessments for individual residents will be reviewed as part of updating of person centred plans	
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • An audit has been carried out to ensure that all personal protective equipment is in date in all areas of the centre. • Cleaning schedules and cleaning records are in place in all houses. • The PIC has introduced an audit schedule. As part of this schedule, to maintain consistency, cleaning audits are completed by staff on a monthly basis. All actions are reviewed by PIC as required.	

• IPC/Covid-19 guidance documents will be updated and available in all houses.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All fire doors in all houses have been audited by maintenance, issues observed on the day of inspection have been completed. Further upgrade of some doors have been scheduled to be completed.

• Person in charge will ensure monthly oversight of fire safety checks & fire drills to ensure that there are no gaps in records and that drills are completed and documented to involve the maximum number of residents that could be in houses and to reflect a night-time evacuation when residents would be in bed and there would only be minimal staffing on duty.

• All resident PEEPs will be updated to reflect the outcome of fire drills.

• Fire evacuation plan for all houses have been updated.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• A comprehensive assessment of need will be completed for resident who did not have one in place on day of inspection.

• The person in charge has scheduled Person Centered Planning (PCP) meetings to occur with each resident and, with his or her consent, their representative staff/key worker will identify their strengths, needs and life goals, meetings will be completed for all residents and all personal plans will be updated by 26th January 2024

• The person in charge will continue to add the updating of care plans to the agenda of monthly staff meetings to ensure oversight and monitoring, ensuring that goals identified for residents are meaningful, that goals are documented with identified persons responsible for supporting residents with these goals within a timeframe for completion.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• All healthcare records will be updated as care is provided

• The person in charge will continue to add the importance of completing all healthcare records to the agenda of monthly staff meetings to ensure oversight and monitoring

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• Intimate personal care plans and health action plans have been reviewed and updated to reflect consistency in care plans.

• The person in charge has scheduled Person Centered Planning (PCP) meetings to occur with each resident and, with his or her consent, their representative staff/key worker will identify their strengths, needs and life goals, meetings will be completed for all residents and all personal plans will be updated by 26th January 2024.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Consultation with individual residents continues regarding hourly checks at night time, if required rationale and consent for night time checks will be clearly documented in residents care plan.

• Monthly residential advocacy forum meetings continue, these meetings will be facilitated to ensure that residents are given the opportunity to become more involved in decision-making processes around their daily lives so that they are actively involved and given the freedom to exercise autonomy, choice and independence.
• Staff members have been identified to support the residential forum meetings, the person in charge will provide guidelines to these staff to ensure that personal information relating to residents is not discussed in this forum.
• Residents will be consulted via residential forum meetings for any future admissions to the centre

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	30/11/2023
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/11/2023
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with	Substantially Compliant	Yellow	30/11/2023

	their wishes.			
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	30/06/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2024
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/11/2023
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	31/08/2023
Regulation	The registered	Substantially	Yellow	30/11/2023

23(1)(d)	provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Compliant		
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/08/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to	Substantially Compliant	Yellow	30/09/2023

	emergencies.			
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.	Not Compliant	Orange	01/09/2023
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/11/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	01/09/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety	Not Compliant	Orange	01/09/2023

	management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 31(1)(a)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: the unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre.	Not Compliant	Orange	12/07/2023
Regulation 32(4)	Where an absence referred to in paragraph (3) has occurred, the registered provider shall notify the chief inspector of the return to duty of the person in charge not later than 3 working days after the date of his or her return.	Not Compliant	Orange	12/07/2023
Regulation 34(1)(b)	The registered provider shall provide an effective complaints	Not Compliant	Orange	01/09/2023

	procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall make each resident and their family aware of the complaints procedure as soon as is practicable after admission.			
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Not Compliant	Orange	01/09/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	01/09/2023
Regulation 05(1)(a)	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	Not Compliant	Orange	31/08/2023

	out prior to admission to the designated centre.			
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	31/08/2023
Regulation 05(6)(b)	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 be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's	Not Compliant	Orange	26/01/2024

	wishes, age and the nature of his or her disability.			
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	26/01/2024
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	26/01/2024
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	24/11/2023
Regulation 09(2)(e)	The registered provider shall	Substantially Compliant	Yellow	01/09/2023

	ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.			
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.	Not Compliant	Orange	01/09/2023