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 15
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	26 September 2023
Centre ID:	OSV-0005395
Fieldwork ID:	MON-0040914

About the designated centre

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

Cork City North 15 is comprised of three purpose-built bungalows which are located within a secure campus setting adjacent to another designated centre and a day activation centre on the outskirts of Cork city. The designated centre can provide full residential care for up to 17 adult residents. Two bungalows are comprised of six individual bedrooms, kitchen, dining and sitting room, music room, laundry and linen room. Each bungalow also has two shared bathrooms and an additional toilet for residents to use. There is a connecting corridor between two bungalows where a staff office and facilities are located. The third bungalow has been restructured to create one self-contained apartment styled dwelling to support one resident and the rest of the bungalow can support a maximum of four residents. The centre supports residents with mild, moderate and severe/profound levels of intellectual disability with many residents presenting with additional complex needs and behaviours that challenge. Residents are supported by a staff team that comprises of both nursing and social care staff by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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 26 September 2023	12:00hrs to 18:45hrs	Elaine McKeown	Lead
Tuesday 26 September 2023	12:00hrs to 18:45hrs	Laura O'Sullivan	Support

What residents told us and what inspectors observed

This was an unannounced-risk inspection of the designated centre. The provider had been placed on a six-month regulatory improvement plan in October 2022. This designated centre was previously inspected on four dates since July 2019, this included two risk inspections in November 2020 and May 2022. Another unannounced inspection had been completed on 8 May 2023 prior to this inspection taking place. The provider was seeking to renew the registration of this designated centre. However, the inspectors were not assured at the time of this inspection that the provider demonstrated services being provided and the lived experiences of the residents had improved since the previous inspections.

The inspectors visited all three houses during the inspection at times that suited the routines of the residents. Inspectors were informed 13 residents were being supported with full-time residential services and one resident was being supported with a shared care service three nights each week. The inspectors met with seven of the residents during the inspection. In addition, the staff team were supporting another resident to transition into the designated centre. This resident was scheduled to remain overnight in the designated centre on the weekend following this inspection.

On arrival the inspectors met with the person in charge who had recently been appointed to the role. Inspectors were given information regarding the assessed needs of the residents which included management of medical issues, mobility status and supports required to assist residents with activities of daily living (ADLs).

On arrival at the first house, the inspectors were introduced to one resident who was being supported by a staff member as they walked independently around the large communal areas of their home. The resident had completed their usual morning routine, was neatly dressed and had been supported with their personal care. The resident was observed to smile and interact with one of the inspectors when introduced. While the inspectors were present the resident was observed to walk towards the front door and request to go for a spin. The staff member informed the resident that they could not go for a spin at that time and it would be the next day before they could go out for a spin. This will be further discussed in the quality and safety section of this report.

The inspectors visited the second house in the afternoon. Three staff were on duty supporting two residents who were in the house at that time. Both residents were in the sitting room, one was sitting on a couch and the other in their wheelchair. There were two staff present at the time in the same room who did not appear to be actively engaging with the residents when the inspectors arrived. The third staff member spoke with one of the inspectors as a walk around of the building was completed. This staff was familiar with the assessed needs of the residents living in the house, including the requirement of a restrictive practice to be in place when a particular resident was in the house. This was found to be adhered to during this

inspection. The kitchen door was not locked at the time the inspectors were present which had been a finding in the previous Health Information Authority (HIQA) inspection in May 2023. Another resident returned to the house after enjoying a trip to the city with an activation staff member. The resident was able to self propel themselves in their wheelchair and was observed engaging with the staff member. The resident reacted positively as the activation staff spoke about their afternoon activities which included some refreshments and a visit to a large toy store. The resident communicated using vocalisations which the staff member was observed to understand. The resident was also supported to have a preferred snack and drink before the inspectors left the house.

On arrival at the third house the inspectors were introduced to three residents. All were located in different areas of the house. One staff member was supporting these residents at the time. One resident was sitting in the dining room having a drink, another was sitting in a large sitting room and the third was sitting in a smaller sitting room. Two of the residents did not directly interact with the inspectors but the third resident did engage in conversation. This resident did not wish to show the inspectors a preferred book when asked by the staff member. The resident had chosen not to have the television turned on at the time. Staff explained how the resident liked to sit in a preferred seat by the window and watch staff and peers passing by. Also, the resident liked to spend time in this space alone. A short time later the inspectors were talking with the staff member and another resident who had just returned from their day service in the hallway. This resident was observed to smile and interact with the familiar staff member during the conversation. The resident in the small sitting room was heard to request the staff to move another peer who had entered the room, out of the space. The staff initially explained to the resident that the peer was not going to stay in the room very long. However, the request was repeated. The staff respectfully encouraged the peer to go into another room.

The inspectors were informed some of the residents from the designated centre were attending day services located on the same campus. The provider had resourced two staff dedicated to supporting activation activities for the residents in this designated centre on weekdays. These resources had been put in place by the provider since the previous HIQA inspection in May 2023. However, it was unclear how activities were planned to ensure all residents were supported to engage in regular or frequent activities. There was no schedule or timetable available for inspectors to review. Staff working in the houses were unable to inform inspectors when residents in their care would be next supported by the activation staff. Activities were being planned by the activation staff and the staff in the houses were verbally informed of any planned activities. This then resulted in staff in the houses planning activities for the remaining residents. In addition, only two transport vehicles were available which were shared between this designated centre and another located on the same campus. This restricted the ability for staff to arrange group activities.

Staff did outline plans for a number of residents to participate in social outings in the weeks after this inspection. For example, one resident was planning to go to visit Dublin Zoo. The inspectors were informed this resident had not been supported

to go on a short break for over 18 months and the resident was looking forward to the planned activity. While some residents had been supported to attend a public swimming pool as the provider's pool was unavailable, other residents who previously enjoyed attending swimming were being offered activities such as bike sessions, mindful art sessions and participating in a running activity if they chose too. However, not all residents chose to participate in these activities and there were gaps evident in some residents involvement in meaningful activities.

Inspectors reviewed the activity record sheets for six residents. These included records of community activities that had taken place in August and September 2023. One resident had not been supported to engage in bowling or socially having refreshments during this period. One spin was recorded which was occurring on the day of the inspection. Another three residents had no activities recorded as taking place on 18 and 21 September 2023. Records of activities for other dates during this period for these residents included television, walk on campus grounds and "toys". One resident had no activity record. The activity record of the resident who was requesting to go for a spin while the inspectors were present had only three entries in their activity chart for September 2023. On 12 and 18 September 2023 the resident went for a spin, one of these was to visit a farm. The other activity was attending the day service activity centre on 21 September 2023.

Following a review of the personal plans for the residents living in one of the houses, inspectors were not assured adequate staffing resources were consistently available to support the assessed needs of the residents to enable them to engage in meaningful activities and to have a good quality of life. Two of the residents required two staff to support their assessed needs and one resident required a dedicated staff to support them during the day. The planned transition of another resident into this house who also had high support needs would also impact the ability of staff to effectively support all of the residents. The new resident required one dedicated staff at all times and in the event of a medical emergency occurring due to a known condition, two staff would be required to support the resident. The inspectors were informed that not all of the required staffing resources for the new resident were secured at the time of this inspection.

In addition, one staff was supporting four residents in another house at the time inspectors were present, but no risk assessment regarding lone working had been identified in line with the providers own criteria for lone working. The inspectors were informed that staff did not engage in lone working in the designated centre but this was not evident on the day of the inspection.

Inspectors were also not assured effective fire safety practices were consistently being adhered to by staff. This had been a finding of the previous HIQA inspection on 25 May 2023 when an urgent action had been issued to the provider regarding Regulation 28 : Fire precautions. While the provider had completed the required fire safety works which included the replacement of a fire door, effective fire containment measures were not evident in the designated centre on that inspection. Similar findings were observed by inspectors on the day of this inspection. A fire door was obstructed from closing in the apartment as an object had been placed at the base of the door to prevent it closing. The side extension panels of the

bedrooms in another house were observed to be opened back while the doors were closed. This did not provide effective containment in the event of the fire alarm being activated or a fire occurring.

Following the HIQA inspections on 25 May 2022 and 8 May 2023 the provider had submitted a compliance plan response to the chief inspector. Not all of the actions outlined in these responses had been adequately addressed or compliance with the regulations maintained. In addition, the findings on inspections had consistently identified improvements were required to be implemented with the service being provided to residents since July 2019. This included actions relating to governance and management and residents' rights.

The next two sections of this report will 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 provided.

Capacity and capability

Overall, this inspection found that residents were not consistently in receipt of good quality care and support. This resulted in poor outcomes for residents in relation to their personal goals and the wishes they were expressing regarding how they wanted to live or spend their time in the centre. There was evidence of improvements being required in the oversight and monitoring in management systems that were in place to ensure the residents received a good quality and safe service.

There had been a number of changes to the person in charge in the previous 12 months in this designated centre. Three different staff had taken up the role since September 2022. The most recent change had taken place on 31 July 2023. While the person in charge was familiar with the residents and the designated centre as they had worked in the setting for a number of years, they had not received a handover from the departing person in charge. This was identified as an issue by the provider's internal auditors in August 2023. In addition, the auditors noted there were an increasing number of gaps in the planned rotas at that time requiring an increased reliance on agency staff. Also, due to a lack of staffing resources the person in charge was regularly providing front-line support to the residents and staff team which adversely impacted on their ability to complete other duties required of their role, including audits and staff supervision. The person in charge also had a remit over the day centre on the same campus at the time of this inspection.

Concerns had been raised in September 2022 by family representatives of the resident living in the apartment regarding the suitability of the space available for the resident. This had been identified in the May 2023 inspection report as requiring

further review by the provider. The compliance plan response submitted by the provider following that inspection outlined that the provider was exploring alternative options for the resident. The time-line for compliance with Regulation 9(3) was 31 December 2023. The inspectors requested an update on the progress to date regarding this issue. However, the person in charge and the person participating in management were unable to provide an update on this issue and records of the concern could not be located at the time of the inspection.

Other family representatives had raised issues of concern relating to their relatives which were either not followed up by the provider or there was an extended delay of over 12 months. For example, on two successive years, 2022 and 2023 a family representative had completed a family survey questionnaire which they had been invited to complete by the provider as part of its annual report. On both occasions they had highlighted concerns relating to the care of their relative's clothing. It was unclear if there was a satisfactory resolution to the issue. Another family representative raised a number of issues of concern in their completed questionnaire in 2022. These included the quality of care, level of communication from the staff team and no answers to their queries. The inspectors were informed that the matters had been discussed with the family but no complaint was logged to show a resolution to the satisfaction of the complainant.

Another complaint had been made by family representatives in August 2022 who had concerns regarding the care being provided to their relative. A case conference was held on 6 September 2022, there was no record of follow up with the family post the case conference in the complaint log. The complaint remained open and unresolved for 12 months until September 2023 when the complaint was closed out.

The provider had not ensured that all details of residents residing in the designated centre were available as required under Regulation 21: Records. For example, the resident who was in the process of transitioning into the designated centre had stayed overnight on the 31 August 2023. Not all of their details were contained in the designated centre's directory of residents including their presence in the designated centre over night on that date. Another resident had been in receipt of medical care in an acute hospital, this information was not reflected in the documentation provided by the provider for staff to complete. Other omissions relating to records were discussed during the feedback meeting at the end of the inspection.

The inspectors observed during the walk about of the designated centre that the registration certification on display in all three houses was not for the current registration cycle. The document was reflective of the conditions of registration that had ended on 26 Feburary 2021.

Regulation 15: Staffing

The provider had not demonstrated that the number and skill-mix of staff was consistently maintained to meet the assessed needs of residents. The roster was shared with another designated centre and it was difficult to establish if the staffing levels were in line with the statement of purpose. In addition, it was not always evident who was the senior staff on duty. For example, on the planned rota for 29 September 2023, both the person in charge, the supporting manager from a nearby designated centre and the clinical nurse manager were scheduled to be off duty. However, it was not clearly evident who would be responsible for the day-to-day running of the designated centre on that date. This was not in line with the protocol that staff had been reminded of during regional meetings with the person participating in management in July and August 2023.

At the time of this inspection there were 6.5 whole time equivalent (WTE) staff vacancies in this designated centre. There were regular relief staff available and some agency staff also working in the designated centre. Two of the staff on duty on the day of the inspection were from an employment agency. Inspectors noted that there were five core staff on planned leave at the time of the inspection which was not in adherence to local protocols to ensure adequate numbers of familiar staff were providing support to the residents in this designated centre.

The actual and planned rota was not accurately reflecting the resources, skill-mix and assessed needs of the residents in the designated centre. For example, one resident required the dedicated support of two staff by day and one by night. This was not evident on the rosters provided for review to the inspectors. The location where agency staff were working was not clearly identified. Inspectors noted on the actual roster that the person in charge was providing nursing support to the adjacent designated centre on the day of the inspection in addition to their own duties. The protocol in place for staffing contingency did not state that staff from another designated centre could provide cover while scheduled to be working in their own designated centre. In addition, the person in charge for the adjacent designated centre was on duty on the day of the inspection and was qualified to provide nursing support to their designated centre.

The resources required to support the planned admission of a new resident were not in place. This resident required one-to-one staff supports.

The inspectors acknowledge, the provider had addressed the staffing resources available to the designated centre to support the activation of the residents. Two whole time equivalent staff were employed to support residents engage in activities at the time of this inspection. However, the inspectors were informed that scheduling of activities for residents in the designated centre was completed by the activation staff. There was no structured timetable available for inspectors to review and staff in the houses received a verbal schedule of planned activities for the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had not ensured a complete training matrix was maintained in this designated centre. Inspectors were not provided with the training details of agency staff as requested on the day of the inspection. The matrix provided to inspectors did not correspond to the staff on the roster. It was unclear from the records provided if all staff had attended safeguarding training.

The provider had completed a training record review on 31 July 2023, which identified gaps in the training completed by staff. This included 18 staff requiring training /refresher training in safety intervention. The provider's internal audit in August 2023 had identified gaps in training for core staff in fire safety, safety intervention, manual handling and safeguarding. While the inspectors acknowledge that training in safety intervention had been scheduled for a small number of staff in August 2023, two staff could not attend due to illness on the day. The inspectors were initially informed no other training dates were available for staff to attend safety intervention training for the remainder of 2023. The inspectors were informed during the feedback meeting that training in safety intervention would be taking place every month until the end of the year.

Gaps in staff training had also been identified in the July 2019 and November 2020 HIQA inspections of this designated centre. Regulation 16 was not reviewed during the risk inspection of May 2022. Findings from the May 2023 inspection demonstrated some progress and review by the provider at that time but gaps in staff training remained. The provider had given an undertaking to be in compliance with the regulation to the chief inspector by 31 October 2023. However, the inspectors were not assured this would be achieved by the provider following a review of the information available to them at the time of this inspection.

In addition, specific training was identified to be required by staff supporting the resident who was due to move into the designated centre. This included mental health and autism training, these training courses were not scheduled at the time of the inspection.

The inspectors were informed all staff had completed online training in Human rights by the end of August 2023.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not ensured that the designated centre was consistently resourced to effectively provide care and support to all residents. This was a finding in the May 2023 inspection. The provider had submitted a date of 31 August 2023 for compliance with the regulation to the Chief Inspector. The management systems in

place at the time of this inspection were not as outlined on the organisation structure in the statement of purpose. There was not a whole time equivalent CNM assigned to this designated centre.

Actions identified on internal audits lacked details of progress/ completion, time lines and the person responsible.
Effective oversight by the provider was not evident during this inspection which included-:

A protocol when the person in charge was on planned leave was not adhered to

The directory of residents did not contain all the required information specified in paragraph (3) of Schedule 3. Information for residents

Not all records for residents who had lived in the designated centre had been maintained as required by Schedule 4.

Not all incidents that were required to be submitted in writing to the Chief Inspector within three days as per the regulations had been completed. Follow up actions outlined by the provider including all staff complete online refresher training in safeguarding by the end of August 2023 had not been completed.

There was evidence of lack of follow up by the provider with issues raised by family representatives.

Not all complaints were followed up as per the provider's own policy and guidelines.

Not all actions outlined in the compliance plans submitted to the Chief Inspector following the 25 May 2022 and 8 May 2023 HIQA inspections had been adequately addressed or compliance maintained at the time of this inspection.

Oversight by the provider relating to escalated risks in the designated centre was not evident at the time of this inspection.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that the quality and safety of care provided for residents required further review. Residents' rights were not consistently promoted. Not all residents were supported to engage in meaningful days and explore different activities and experiences. Findings in previous HIQA inspections have demonstrated ongoing non-compliance or sub-compliance in regulations reviewed pertaining to the quality and safety of care provided to residents in this designated centre.

The provider had commenced introducing a new format for staff to review personal

goals for residents. However, one resident had a goal to visit their family and home, which was an activity that was frequently happening for the resident. Another resident had a goal to go bowling once a week. There was no record of this activity taking place. During the inspection, staff supporting one of the residents was asked if they knew what the personal goals were for the resident in their care. They were unable to provide an answer to this at that time. When an inspector asked if the staff knew where to locate the necessary information they were also unable to provide this information. The provider's most recent internal audit of 9 August 2023 found no evidence of goal progression for residents. There was no review schedule in place for personal plans. Some of the residents' healthcare-action plans lacked nurse reviews. The auditors requested a review of all health care documents. As previously mentioned in the report actions identified in audits lacked details of progress/ completion and time lines. As previously mentioned in this report, the provider had appointed two WTE staff members whose role was to support the residents in this designated centre engage in meaningful activities. However, inspectors were not assured all residents were being effectively supported to engage in activities of their choice regularly. During the inspection one of the activation staff was observed to engage well with one of the residents with whom they were providing support. They had been out in the city for the afternoon. However, the same resident was informed by the activation staff that they would be involved in another activity the following day while two other residents in the same house had not engaged in an activity outside the designated centre on the day of the inspection.

The inspectors acknowledge that residents may decline activities when offered to them. However, this was not evidenced in documents reviewed. In addition, the lack of a structured activation timetable for the residents in the designated centre did not provide assurance to the inspectors that all residents were offered the opportunity to engage in different and meaningful activities regularly. It was noted that weekly residents' meetings had recommenced since 20 August 2023 in the designated centre. However, on review of some of the meeting notes one resident had requested more time and activities outside of their house on 11 September 2023. There was no such activities documented for the resident since that date. On the 9 August 2023, two residents had discussed a resident's forum going to a local wildlife park on the train. This had not been completed. The provider has outlined in their compliance plan submitted to the Chief Inspector following the May 2023 inspection that actions would be taken to ensure residents would be supported to engage in meaningful activities outside of the designated centre. The provider planned to be in compliance with Regulation 9(2)(b) by 30 November 2023. However, sufficient progress towards attaining compliance by the provider by that date was not evident at the time of this inspection.

The inspectors were informed a compatibility assessment had been completed by management on 20 July 2023 regarding the planned transition of a resident into one of the houses. On review the assessment detailed the special requirements of the resident and the resources required to ensure the safety of the resident and the peers which they were being proposed to live with. There were details of support being provided for a limited number of hours by familiar staff outside of the designated centre. In addition, the assessment clearly outlined that the surrounding

environment for the new resident needed to be kept clear of all items containing foam or jelly-like consistency. Staff spoken too were unaware of this on the day of the inspection and one resident was observed to have an item which was made of soft jelly-like consistency during the inspection. The inspectors had been informed that the resident had already stayed overnight on 31 August 2023. However, the bedroom when visited by one inspector was found to have basic furniture which included a hard plastic chair. Staff were unsure if this was a preferred type of chair for the resident. In addition, the was a door missing on the under sink unit.

The inspectors were informed at the beginning of the inspection by the person in charge that there was one escalated risk in the designated centre. This related to staffing vacancies. This risk had been accepted in line with the provider's process by senior management. However, on review of the risk register there were nine high-rated risks. These included the service user experience which had a review date documented as "review as soon as possible". Other high-rated risks were documented as "monitor" with no additional controls being documented. This was not in line with the provider's policy and procedures. In addition, inspectors were not assured all risks had been identified for this designated centre. This included lone working staff. On the day of the inspection two of the houses were observed by inspectors to have a single staff member supporting multiple residents.

Regulation 26: Risk management procedures

The provider had not ensured effective systems were in place in the designated centre for the assessment, management and ongoing review of risk.

The provider had not ensured all staff were made aware of the updated risk management policy. The inspectors were informed during the inspection that the policy had not been reviewed since 2021. The version available for review was not the up-to-date version. However, inspectors were informed at the feedback meeting that an updated version had been available since September 2023 and had been circulated by the provider in August 2023.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider has consistently not demonstrated effective fire safety containment measures were maintained in this designated centre.

While the provider had completed the required fire safety upgrade works as outlined in their previous compliance plan responses to the Chief Inspector, findings during

this inspection identified similar issues to the previous two inspections of May 2022 and May 2023. Fire doors were been held open or obstructed from closing and fire door extension panels were opened back preventing effective containment in the event of a fire and the alarm being activated.

On the day of this inspection, there was damage evident to a fire door and intumescent strip in one of the houses. There was a damaged glass panel on another fire door, this was awaiting repairs at the time of this inspection. However, this was not the first time damage to the same glass panel had occurred in the apartment setting in one of the houses. This was also damaged at the time of the May 2023 inspection and had been repaired. The inspectors were informed the recent breakage had occurred two weeks prior to this inspection. There was wooden panelling observed to be in place while suitable replacement glass was awaited to repair the damage.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The registered provider had not ensured that adequate arrangements were in place to meet the assessed needs of each resident.

Not all residents' personal plans had been subject to regular review. Residents' personal goals were not always being progressed in line with their expressed wishes. The provider had expected to be in compliance with Regulation 5(6)(b) by 30 November 2023, as per the response submitted to the Chief Inspector following the May 2023 inspection. Evidence of progress to attaining compliance by that date was not present on the day of the inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had not provided assurance that actions taken since the previous inspection in May 2023 had effectively supported all residents, in line with their wishes to engage in meaningful activities outside of the designated centre. In addition, the progress evident did not demonstrate the provider would be in compliance with Regulation 9(2)(b) by 30 November 2023 as outlined in the compliance plan response submitted to the chief inspector following the May 2023 inspection.

Following a review of some residents' personal goals, it was evident some remained tokenistic in nature while others were not documented as progressing.

Not all residents could access all communal areas of their home as they wished. As previously mentioned one resident was requested to leave a sitting room as another resident did not wish to be in their company.

There were no details or update available of alternative options regarding the living arrangements for one resident being supported in the apartment. This resident's family had expressed concerns about the suitability of the living space in August 2022. The provider had outlined that compliance with Regulation 9(3) would be attained by 31 December 2023. It was not evident sufficient progress had taken place at the time of this inspection for the inspectors to be assured that this would be achieved by the provider as outlined in the compliance plan submitted to the Chief Inspector. In a quality and safety audit completed on 23 August 2023, it was documented that the safeguarding plans were discussed with family representatives but there was no mention of any discussion with the residents having taken place.

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	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City North 15 OSV-0005395

Inspection ID: MON-0040914

Date of inspection: 26/09/2023

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 centre's roster has now been separated from that of the adjacent centre. • New roster for Cork City North 15 clearly indicates the number and skill mix of staff in the centre each day. • The PIC will ensure that senior staff on duty in the absence of the PIC is indicated on the roster each day. • Allocation of leave protocol has been updated since the inspection. The PIC will ensure to adhere to maximum leave protocols in place in the centre. • Locations of agency staff will be indicated on the centre's roster going forward. • Staffing vacancies to be filled (1 x staff nurse, 1 x CNM1 and 4.5 C/A) The Registered provider has ensured that all current staffing levels were reviewed with the PIC, PPIM and HR. An ongoing recruitment campaign is in place to actively fill staff vacancies. • Business case submitted to HSE for additional funding / social care workers. Please refer to Registered Providers statement in Regulation 23 Governance and Management. • The registered provider will ensure the right number of staff and skill mix is in place to meet the assessed needs of the residents in this centre, as outlined in the SOP. **"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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The centre's training matrix has been updated since the inspection and the PIC will audit same on a monthly basis. • Names on training matrix now directly correspond with names on Cork City North 15's	

roster.
• Additional training dates have been sought for safety intervention training – An Cuan Regional Support Service are providing training onsite.
Autism training is being scheduled by the PIC to support new resident in house 3 – An Cuan Regional Support Service providing this training also.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider has submitted a business case and resource request to the HSE, particular to this designated centre. Central to this submission are the Registered Providers findings relating to the significant increase in the assessed needs of residents, as well as an increased level of dependency. The business case reflects a requirement for an increase in staffing levels by 25% which is equal to 8 additional whole time equivalent staff. The senior management team continue to meet with the HSE. In advance of any commitment, agreement or assurances, the registered provider has committed to the following actions to maintain and achieve regulatory compliance:

• Current Staffing vacancies to be filled
• Governance protocols have been reviewed and updated since the inspection. PIC is aware of same and will adhere to all protocols in place in relation to effective governance and oversight of the centre.
• Directory of residents now contains all required information as per regulation.
• The PIC will ensure that all notifications are submitted to HIQA in line with regulatory requirements. In the event of PIC absence local governance protocols are in place to ensure the timely submission of 3-day and / or other notifications.
• Issues raised by family members of residents in feedback surveys have been logged as complaints and all actions taken to resolve complaints have been documented by the PIC.
• The centre’s risk register has been reviewed and updated since the inspection.

“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 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Organisational risk management policy has been reviewed.
• The centre’s risk register has been reviewed and updated including escalated risks to the provider. All future escalated risks will be the subject of discussion between the PIC and their PPIM at monthly review meetings. All identified risk matters of concern will be escalated by the PPIM to the Regional Managers / Chief Operations Officer forum.
• Lone working – as a specific risk, has been reviewed and included in the risk register.
• The PIC has reviewed and updated risks to reflect fire safety issues within the centre.
• The PIC will ensure to review risk register on a 6 monthly basis or sooner as required.

• The Audit Safety and Risk committee has re-commenced within the centre.	
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC is completing weekly fire safety audits in the centre in order to ensure compliance in this area.
• Fire safety officer will be assigned per house on a daily basis and this will be indicated on the centre’s roster each day to encourage a culture of responsibility amongst staff in relation to fire safety. This will include daily fire safety checks, coordinating of fire drills and ensuring that all fire doors kept closed and free from obstruction.
• The PIC will escalate any maintenance repair delays to the PPIM if they impact on Fire and Safety.
• All fire and safety equipment or measures that are the subject of repeated damage or unwarranted attention shall be notified to maintenances for the purposes of securing an alternative that is less likely to be damaged.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The PIC has developed a review schedule for all personal plans and staff / keyworkers have commenced work on same. The PIC and PPIM will meet bi-weekly to review a selection of different personal plans at each meeting. The PPIM has scheduled the bi-weekly reviews with the PIC. Personal plans will be audited and action plan completed for staff to ensure that progress continues.
• Keyworkers list updated and staff have been assigned responsibility for updating personal plan.
• Assessment schedule in place. Key nurse allocated for completion of assessments for each individual in the centre. This will include updating of health support plans.
• Staff have completed goal setting training which support/develop achievable meaningful goals for each individual. Further training dates have been requested and a schedule will be put in place by the PIC once dates have been confirmed.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• All residents in the centre will continue to be offered choices of activities. Where residents refuse activities staff will ensure to document same. The PIC will schedule monthly review meetings with activation staff in the centre to ensure good oversight of all activities and choices being offered to the residents. The PIC has allocated protected time each Friday for the activation team to plan and schedule activities for the following week in conjunction with the residents and other staff in the houses.
• Further training dates have been requested for goal setting to support staff to work with residents on identifying more meaningful goals. The PIC will put a training schedule in place once dates have been received.
• All outstanding PCP meetings have been scheduled and aim for completing 30/11/2023. Goals will be identified during these meetings and reflected in each personal plan why they are important to the resident and identify steps to take to support residents in achieving these goals.
• The PIC has requested support from the advovacy officer in relation to meaningful goal

setting for residents.
• All residents can access an independent advocate. Information is available in easy to read format in each resident’s support plan and in the resident’s guide.
• In the event of residents requiring safeguarding plans the PIC will ensure that residents are involved in any discussions around the safeguarding issues and that their safeguarding plan is available to residents in an easy to read format (where applicable).
• In relation to alternative accommodation for one resident (house 3 apartment) the PIC has contacted the resident’s independent advocate to discuss the issues. The PIC has also put in a referral for a full multi-disciplinary review / assessment of need for this resident. Once this has been completed the PIC will arrange to meet with the PPIM and COO to discuss findings / recommendations and possible alternative accommodation solutions.

“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"

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	27/02/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	30/11/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Not Compliant	Orange	27/02/2024

	as part of a continuous professional development programme.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/06/2024
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	27/02/2024
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 emergencies.	Not Compliant	Orange	30/11/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety	Not Compliant	Orange	31/12/2023

	management systems are in place.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2023
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2023
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 wishes, age and the nature of his or her disability.	Not Compliant	Orange	31/12/2023
Regulation	The registered	Not Compliant	Orange	31/12/2023

09(2)(b)	provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			
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	31/12/2023