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 7
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	04 July 2024
Centre ID:	OSV-0003297
Fieldwork ID:	MON-0043486

About the designated centre

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

Cork City North 7 comprises four houses on a campus setting in Cork city. There are other designated centres on this campus. The centre can currently provide a residential service to 25 people, who live in the centre on a full-time basis. The centre provides services to both males and females, over the age of 18 years. Each house is a two-storey building with the same layout. This includes a kitchen, separate dining room, sitting room and sun room. Each house has both downstairs and upstairs bedrooms. Some residents in each house share their bedrooms with others. The centre is staffed at all times. The staff team consists of care assistants, nurses and activities coordinators. The stated aim and objective of the centre, as outlined in the statement of purpose, is to promote a welcoming and homelike environment ensuring always that residents' dignity and safety is promoted.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

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
Thursday 4 July 2024	09:20hrs to 17:00hrs	Deirdre Duggan	Lead
Friday 5 July 2024	08:40hrs to 16:40hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed and from speaking to staff and management, overall residents were receiving good care and support in this centre. The provider was making progress in relation to the planned partial decongregation of the centre and improvements were noted in relation to overall compliance with the regulations in the centre. Some issues in relation to the levels of activity provided for some residents and personal plans were identified.

Cork City North 7 comprises four two-storey houses on a campus setting in Cork city. There are other designated centres, and a day service operated by the provider also based on this campus. Some residents had their own bedrooms, and others shared bedrooms. There were 24 residents living in the centre at the time of the inspection. The registration of the centre had been renewed with a reduced capacity of 25 residents in 2023. Since the previous inspection in February 2023 one resident had moved to another designated centre based on the same campus due to a change in their assessed needs.

This was an unannounced inspection and took place over two consecutive days. The inspector had an opportunity to walk around and spend time in all four houses in the centre and visited each house at least twice over the course of the inspection and spent time reviewing documentation and observing residents going about their daily routines in all four houses of the centre. Some documentation was also reviewed in an office on campus. All 24 residents were met or observed in their homes during the inspection.

Residents were observed to be overall content in their homes and were relaxed in the company of the staff that supported them. Some improvements in relation to consistency of the staff team and the staffing arrangements in some houses had taken place since the previous inspection, and the inspector saw that this was having a noticeable positive impact. While some of the houses remained busy environments, residents were overall seen to be more relaxed and there was a noticeable reduction in the noise and activity levels noted in one of the houses visited by the inspector during the previous inspection. The inspector noted that the residents in this part of the centre were happy for the inspector to spending longer amounts of time in their home, when compared to the previous inspection.

All parts of the centre were observed to be clean, homely and nicely decorated. Residents' photographs were on display in communal areas and some areas were being painted or had recently been painted at the time of the inspection. New flooring had also been laid in some areas and was planned for others. Residents had access to comfortably furnished communal areas. As noted on the previous inspection, there was a fish tank in one sitting room in another the conservatory area was fitted with lights and a projector which was used to show films on the wall. Several televisions were available for the use of residents in communal areas of

each house and residents also had televisions in their bedrooms if they wishes.

Residents' bedrooms were nicely decorated and personalised to reflect residents' interests and preferences. Photographs, and residents' preferred items were on display if desired. Eight residents continued to share a bedroom with one other person. In these rooms, each resident's own area in the room was clearly outlined, as were their facilities to store their belongings. Most shared bedrooms were divided with a partition wall. In the other shared rooms a retractable privacy screen was available for use should it be required. The inspectors saw bedrooms that had been shared in the past but were now single occupancy and these provided additional areas for residents to relax in their bedrooms.

Residents were seen to be comfortable in the presence of the staff that supported them and were familiar with the PPIM who accompanied the inspector during the initial walk-around of the centre. Staff told the inspector that some residents preferred to spend time in specific chairs or areas of their homes. Some residents were observed enjoying snacks and meals in the dining room, and others were observed relaxing while watching TV or listening to music in the sitting room and conservatory areas of their homes. Some residents were observed in their bedrooms relaxing and a number of residents, who previously shared rooms, had access to sitting room areas in their bedrooms and were observed spending time in these. During the inspection, the inspector heard and saw staff interacting in a variety of ways with residents. In one house, a staff member was heard singing with residents, which they appeared to enjoy. One resident was observed having her nails painted by staff. Some residents were also observed preparing to go to day services and to go out with the activation staff. In one house, a resident was observed to request to go walking often and was seen to be facilitated to do so with staff at a convenient time. Some areas of the centre were seen to be very busy at specific times, but overall, the inspector saw that the atmosphere in each house was calm and relaxed. The inspector saw that the activities offered to residents varied across each of the four houses. In some houses, residents appeared to spend longer periods watching TV or sitting in the communal areas of their home, while in others, residents appeared to be offered more stimulation and activiation and were also leaving their houses regularly. This will be discussed further later in this report.

Staff were present in all areas of the centre at all times and the inspector met with a number of the staff on duty over the two day period. Staff were observed an heard to interact with residents in a respectful and caring manner. Some staff spoken to demonstrated a strong commitment to ensuring the residents in the centre were offered the best service possible. Staff were observed to knock on bedroom doors before entering and were heard to offer and provide personal care in a respectful manner.

Overall, this inspection found that there was evidence of improved compliance with the regulations and that this meant that residents were being afforded better quality services to meet their assessed needs. 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

Management systems in place in this centre were ensuring that overall the services being provided were safe and appropriate to residents' needs. This inspection found that the management and staff team in place in the centre were familiar with the residents living in the centre and were committed to providing an effective service that met their assessed needs. There was a clear management structure present and overall there was evidence that the management of this centre were maintaining oversight and that these individuals maintained a strong presence in the centre. Provider oversight was maintained through reporting and auditing structures and ongoing efforts were being made to bring the centre into compliance with the regulations.

There was a clear management structure present in this centre. The person in charge reported a regional manager who was also a person participating in the management (PPIM) of this centre. The PPIM reported to the Chief Operations Officer (COO) who in turn reported to the Chief Executive, who reported to a Board of Directors.

There had been changes to the management of the centre since the previous inspection. A new person in charge had been appointed and a new person participating in the management of the centre, a regional manager, had also been appointed. The person in charge was unavailable at the time of the inspection, but was able to attend feedback remotely following the inspection. The PPIM was present for and facilitated the inspection in the absence of the person in charge. Another person in charge based on the same campus who was familiar with the centre, was also available during the inspection.

The previous inspection of this centre in February 2023 had found that the provider had not implemented the decongregation plan they had previously submitted to the Chief Inspector within the specified timelines, and that they would not meet a restrictive condition attached to the registration of this centre. An updated plan was submitted and accepted by the Chief Inspector that set out that the provider would decongregate 10 residents from this centre by the end of 2025 and this was accepted prior to the renewal of the registration of the centre. When the registration of the centre was subsequently renewed in July 2023, two restrictive conditions were applied by the Chief Inspector. One related to no new admissions to the centre. The other specified that the provider would adhere to the timelines outlined in the partial decongregation plan submitted to the Chief Inspector.

This unannounced inspection was carried out to assess the progress of that plan and the providers actions as outlined in the compliance plan received following the previous inspection. It was found that the provider was now making some progress with this updated plan to decongregate some residents from this centre.

Improvements were also noted in relation to some other aspects of the service being provided in the centre, although some areas of non-compliance remained.

This inspection found that, although residents had not yet moved into community based homes, suitable accommodation had been sourced and plans were in place for four residents to transition from the centre, with further planning reported to be taking place in relation to the remainder of the partial decongregation plan also. One resident had already moved out of the centre to another centre on the campus due to their changing needs as per the plan in place. Appropriate housing had also been identified for a number of residents in community based homes. The transition process for one resident was at an advanced stage and the inspector was told about, and provided with, the transition plan for this resident and this showed that this move had been carefully considered and was being completed in line with the indicated wishes and preferences of the resident. Accommodation for three more residents had also been sourced and assessments were underway to ensure that this potential transfer was appropriate for the identified residents. Attempts were also being made to source alternative accommodation for one resident closer to the area that they were from, where they would have natural family supports also. The PPIM told the inspector that they were actively engaging with the property acquisitions manager also in relation to sourcing suitable bungalow style accommodation for the remainder of the residents that were planning to move out of the centre.

Aside from the actions relating to decongregation, the inspector also reviewed the other actions outlined in the previous compliance plan and saw that good progress had been made in completing most of these. A staffing review had been completed and staff recruitment had resulted in a more consistent staff team. Notifications were being reported as required. Some minor issues in relation to this was discussed with the person in charge during the feedback session.

Staff spoken with spoke positively about the supports offered to them by the management team in place and were familiar with them. Staff reported that the management team in the centre visited the houses regularly, including the person in charge and the regional manager (PPIM). Staff also confirmed that they took part in regular performance reviews.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

Overall, the registered provider was ensuring that the number of staff was appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre. A planned and actual staff rota was maintained in the centre. The centre was staffed by a core team of suitably

skilled and consistent staff that provided continuity of care for residents.

The centre was staffed by a large team of nursing staff, health care assistants and activation staff. Forty one staff members were named on the rota at the time of the inspection, including local management. There were three care staff vacancies, one nursing staff vacancy and a vacancy in the activation team identified. While some staff vacancies remained, gaps in the roster were being covered by regular and relief staff. Since the previous inspection the consistency of the staff team had improved and less agency staff were in use in the centre. There were ongoing recruitment efforts by the provider. Staff rotas for a 14 week period were viewed and these showed that agency staff had been employed in the centre on only two occasions during that period, with one of these occasions being to supplement staff during a COVID-19 outbreak in the centre.

Nursing care was available to residents within the staff team if required and some houses had a nurse on duty . A regular core staff team worked in the centre providing continuity of care to residents and there was ongoing recruitment to fill any identified vacancies. The staff rota maintained in the centre showed that, overall, residents in each houses were generally supported by two or three staff during the day and either one or two staff at night. This showed that staffing levels had improved since the previous inspection. There were some occasions identified where staffing was reduced due to unanticipated absence, such as during a COVID-19 outbreak but staffing levels had been maintained at safe minimum levels as outlined in the statement of purpose for the centre. Some further information in relation to this were requested from the person in charge following the inspection and this was provided.

The inspector observed sufficient staff on duty during the inspection to cater for the needs of the residents in the centre. Staff reported that additional staff were generally provided in one house to support a resident with specific needs and that this had resulted in a substantial decrease in the number of adverse incidents in this location and was contributing to an improved quality of life for all of the residents living there. Although some staff working in the centre reported that staffing could sometimes be an issue, the inspector found little evidence that staffing levels in the centre were impacting on the safety and quality of the care and support provided to residents.

Judgment: Compliant

Regulation 23: Governance and management

For the most part, provider oversight was being maintained in this centre through reporting and auditing structures and ongoing efforts were being made to bring the centre was into compliance with the regulations. While the provider was now actively working towards the partial decongregation plan in place for this centre and some improvements were noted since the previous inspection, some continued

areas of non compliance had not been fully addressed, particularly in relation to personal plans and activation for some residents. These issues were ongoing and although this had been identified by the provider through their internal systems, and there was evidence of some action in relation to these issues, they continued to impact on some residents.

Aside from this, management systems in place were ensuring that the service provided was appropriate to residents' needs. Documentation reviewed by the inspector during the inspection such team meeting minutes, the annual review, and the provider's report of the most recent six monthly unannounced inspection, showed that the provider was maintaining good oversight of the service provided in this centre and that governance and management arrangements in the centre were effectively identifying issues.

For example, an outbreak review had been completed following a COVID-19 outbreak in the centre that impacted one resident and a number of staff. This showed that the response to the outbreak meant it was contained to one location and mostly confined to the staff team, and learnings were identified to inform future practice in the centre.

An annual review had been completed in respect of the centre and the inspector reviewed this document. This included evidence of consultation with residents and their family members. Unannounced six-monthly visits were being conducted by a representative of the provider and the report on the most recent of these, conducted in May 2024, was reviewed also. These unannounced visits are specifically required by the regulations and are intended to review the quality and safety of care and support provided to residents and it was seen that this report assessed a number of relevant areas related to residents' care and the governance of the centre and identified actions required. Some of the issues identified during that audit were also identified during this inspection, and there was evidence of some progress in relation to some of these.

Meeting records viewed showed that team meetings were taking place, generally on a quarterly basis and pertinent issues were discussed during these. Staff members spoken to in the centre reported that the person in charge was very supportive to the staff team and that they would be comfortable to raise any concerns to any of the management team.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was present in the centre and contained all of the information as specified in the regulations. This document had been updated to reflect changes in the management of the centre that had taken place since the previous inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Overall, incidents had been notified to the Chief Inspector as required. The inspector reviewed incident reports in respect of the centre and other documentation in respect of the centre that showed that the person in charge had notified adverse incidents as specified in the regulations to the office of the Chief Inspector. However, some incidents that were required to be reported within three working days had not been notified within the required timeframe. For example, two potential safeguarding incidents were incorrectly submitted under the quarterly notifications for the centre.

Judgment: Not compliant

Quality and safety

The wellbeing and welfare of residents in this centre was overall being maintained by a good standard of evidence-based care and support. Overall safe and good quality services were provided to the twenty-four residents that lived in this centre and residents were seen to be happy and content in their homes. Improvements had been made across a number of areas since the previous inspection and this appeared to be contributing to a better overall quality of life for residents. Based on what the inspector found and was told during this inspection, further work was required to ensure that adequate activity was planned and facilitated in the centre to provide all residents with equal opportunities and ensure all residents were being offered adequate and appropriate activation.

A number of areas of non compliance that impacted on the quality and safety of residents had been addressed since the previous inspection. For example, restrictions that had not been identified prior to that inspection had all been reviewed with efforts made to remove restrictions. For example, in one house, the kitchen was no longer being locked due to staffing levels. This door was observed to be open during the inspection by the inspector. The centre was observed to be clean throughout on this unannounced inspection. Some maintenance and upgrading works had been completed since the previous inspection and was continuing at the time of this inspection, including painting and new flooring in some areas. From a sample of files reviewed, residents were seen to be receiving appropriate dental care and behaviour support plans were in place for residents that required them.

Overall, residents were seen to be happy and content in their homes and enjoyed good care and support in this centre. Residents had access to equipment and allied

health professionals if required and a committed staff team that were familiar with the residents was in place. Some continued areas of non compliance were identified however, particularly in relation to personal plans and general welfare and development. While some improvements were noted, some personal plans still required review and updating and not all residents were seen to have equal opportunities to activity, occupation and community access.

As will be discussed under Regulation 13, residents' access to external and internal activities was varied across this centre. There was evidence that some residents were getting out and about and partaking in activities very regularly. For example one resident had recently celebrated their birthday with a special night out in the city and a party in their home with family and friends. Other residents were seen to regularly go on bus drives and for walks and visits to cafes and restaurants as well as activities such as baking, hand massage, music, football and other activities offered in their homes. Three residents had visited a local seaside town the previous weekend and enjoyed a day out. However, as will be discussed below, all residents did not appear to be offered the same opportunities or choices in relation to activity and community access. This had been highlighted also in previous inspections and in the providers' annual review and six monthly provider audit. It is acknowledged that there did appear to be some improvements in this area since the previous inspection, and there was evidence that the some efforts were being made by the management team to address this ongoing issue and the root causes contributing to it.

The provider had completed a safeguarding review in the centre since the previous inspection and there was evidence that significant work had been done to bring the safeguarding documentation up-to-date with other actions also reported to be completed with the staff team. One resident had sustained some injuries from falls since the previous inspection and the inspector reviewed the documentation in place around this. Updated risk assessments and health support plans were viewed in respect of this resident and there was evidence of good healthcare supports being provided to them.

Overall, staff spoken to were familiar with residents and their support needs and were able to provide information for the inspector on request. Staff presented as very aware of residents' rights, residents' likes, dislikes and assessed needs, and of the procedures in place for safeguarding residents. One staff member told the inspector how important the welfare, safety and happiness of residents living in the centre was to the staff team.

Regulation 13: General welfare and development

Access to opportunities and facilities for occupation and recreation for residents in this centre was seen to vary. Some residents were provided with very regular occupation and access to internal and external activities. However, documentation such as daily notes and activity records for seven residents reviewed in the centre

showed that some residents did not often leave the campus or partake in regular activities on or off campus and that the registered provider was not ensuring that all residents had opportunities to participate in activities in accordance with their interests, capacities and developmental needs.

There was evidence that residents were supported to maintain and develop relationships with important people in their lives, such as family members and some residents were supported to visit home if desired. All of the staff spoken to during the inspection about resident activities told the inspector that residents left the centre on a regular basis, although sometimes residents might be curtailed due to specific medical needs. One staff member spoken to told the inspector about the activities that were offered in the house they were working in and this account was seen to be reflective of what the inspector observed during the inspection. However, activity records viewed for some residents in other locations showed that this was not consistent across all locations. During the inspection, staff were noted to offer activities such as tabletop activities, walks on the campus and some external activities to some of the residents living in some houses, while others were observed to spend time sitting in communal areas watching TV or moving about their homes. Some residents were observed to engage staff as they passed and one resident was observed to lead staff to the door requesting to go out for a walk. Generally, this was facilitated while the inspector was present. Some residents attended the on-site day service centre for activation. Overall, from observations on both days of this inspection, the inspector saw that the level of activity engaged in by residents varied between the houses visited.

Activity records reviewed showed that some residents regularly left the centre for bus "spins" and other activities. It was not always clear if residents left the bus during these outings or were offered this choice. Access to the community was also sometimes reported by staff to be restricted due to specific assessed needs, such as higher medical needs or by staffing. For example, one resident had a goal to commence shopping for their own personal items but the inspector saw that staff were still purchasing these on behalf of the resident. Staff told the inspector that this was due to nursing staff being required to be with this resident when leaving the centre and that this made it difficult to plan external activities with this resident. The inspector spoke with the PPIM of the centre about this issue and was told that this issue had recently been identified by the management of the centre and staff been reminded of the arrangements that were in place to support other residents to allow the nurse rostered in this house to support this resident to access the community. The inspector also noted that some efforts to engage this resident in external activities had recently been documented.

Although staff also reported staffing and transport to be a barrier with external activities, the PPIM confirmed that generally there were sufficient staff on duty and transport was available to staff to plan external activities. The PPIM acknowledged that further work was required out to enhance staff awareness and confidence in this area and ensure that all residents were being offered equal opportunities to access the community.

Two activity coordinators were assigned to this centre but one of these posts was

vacant at the time of the inspection. The inspector also saw that the second individual was sometimes redeployed to frontline work in the centre if staffing levels were reduced. This did impact somewhat on residents opportunities to avail of this service. However, these roles were designed to complement the frontline staff role in providing opportunities for activation for residents and this staff vacancy did not account fully for the lack of activation noted in some houses.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place for for residents and a sample of four of these were reviewed by the inspector. Findings in relation to residents' personal plans varied. A sample of records viewed indicated that annual multidisciplinary team meetings were taking place for residents. Support plans were in also seen to be in place that provided good guidance to staff about the supports residents required to meet their healthcare, social and personal needs. Some changes had occurred since the previous inspection that addressed some of the issues found at that time in relation to the centre meeting the assessed needs of residents.

Some residents' person centred plans were seen to be appropriately documented and had been reviewed with residents within the previous year, with documentation in place to show that residents were setting and achieving goals. Of the sample reviewed, one resident was overdue their annual person centred planning meeting by three months. It was noted that there was some evidence of ongoing keyworker consultation with this resident and most of their goals had been completed since the previous person centred planning meeting. In some of the plans viewed there was clear evidence of progression and ongoing review of goals documented in Goal Action Plans. Staff spoken to were familiar with the goals that residents had and there was evidence of regular keyworker meetings that showed residents were consulted with about their goals. Some residents had been supported to take a break away, and other goals achieved by residents included taking part in classes, visiting places of interest, learning a new skill or attending specific events of interest to them.

However, the inspector saw limited evidence in some of the other plans that were reviewed to show that these residents were being afforded regular opportunities to set and achieve goals. In two of the plans reviewed, meaningful goals had been identified and were documented, but there was limited evidence of ongoing review of these goals or that plans were being updated as circumstances changed. For example, the documentation viewed in one residents plan showed that during their person centred planning meeting in January 2024, a number of short and long term goals had been identified and recorded, with most of these focused on increasing community access and social activities for the resident. At the time of the inspection, the inspector saw that one social outing was documented since then, in June 2024. There was no other evidence that the resident had made any progress with the

majority of the goals set during their annual person centred planning meeting and no rationale was documented for this. The provider had identified some of these issues during the six-monthly uunannounced audit of the centre completed in May 2024 and there was some evidence to suggest that increased efforts had been made since then to address this issue.

Judgment: Not compliant

Regulation 6: Health care

The registered provider was providing access to appropriate healthcare for residents, including access to a general medical practitioner, who visited the centre regularly. Healthcare records were reviewed in detail for two residents in the centre and a sample of records from other residents files were viewed also during the review of documentation in the centre. There was detailed information recorded in each residents' personal file about their healthcare needs and how these were supported in the designated centre. Healthcare action plans were in place for identified healthcare needs and the records reviewed showed that residents were supported to access appropriate healthcare and had access to appropriate health and social professionals. Residents had received significant allied health input including occupational therapy, dental input, optician and neurologist. Mental health supports were provided where required and residents had add access to both psychology and psychiatry services as needed. Residents were supported to make and attend healthcare appointments. Documentation also showed that residents' medications were being reviewed where appropriate. Nursing support and expertise was available and provided to residents as required from the staff team.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' were seen to have positive behaviour support plans in place that provided good guidance to staff supporting them.

A sample of three positive behaviour support plans was reviewed. One of these was due for review but this had been identified by the provider prior to this inspection. These plans were seen to be comprehensive, detailed and provide good guidance to staff about how the residents should be supported in line with best practice. The inspector saw that in response to a specific incident, a protocol had been put in place to guide staff in relation to one resident accessing an outdoor area.

There were some restrictions in place in this centre. These in were in place to promote the safety and wellbeing of residents and the local management team and

staff team were able to provide a rationale the restrictions in place. The documentation viewed in respect of one house showed that restrictions were being identified, with a risk assessment in place also for each restriction identified. This documentation had last been reviewed and updated by the person in charge within the previous month.

Judgment: Compliant

Regulation 8: Protection

The inspector reviewed the safeguarding documentation in place for the centre in detail, including the documentation in place in respect of any safeguarding incidents reported to the Chief Inspector since the previous inspection. The documentation showed that any reported incident, allegation or suspicion of abuse since the previous inspection were being responded to by the person in charge, including investigations and actions taken. Where appropriate safeguarding plans and risks assessments were seen to be in place and these included measures required to ensure that residents in this centre were safe, such as additional staffing in some areas at specific times for example.

From reviewing the safeguarding documentation, it was evident that a significant body of work had recently been completed in the centre in this area, including a recent review of safeguarding incidents dating back a number of years. The provider had also commissioned a review of the safeguarding practices in this centre earlier in 2024 and this was discussed with the PPIM during the inspection, including any learning's from this review.

Training records reviewed showed that the person in charge had ensured that almost all staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. One new staff member was due to complete training and the person in charge confirmed this was completed in the week following the inspection. Easy-to-read safeguarding information was viewed in the centre and staff spoken to were aware of the providers' safeguarding procedures. Staff told the inspector that they felt residents were safe in the centre and would be comfortable to report any safeguarding concerns they had.

The information received by the centre following one specific incident indicated that a number of actions had been taken in response to the incident and on review of this, these were seen to have been completed at the time of the inspection.

Some peer-to-peer incidents had been reported that suggested that, at times, resident incompatibility was an issue in some areas of the centre. The inspector discussed this at length with the PPIM and staff in the centre, and reviewed the safeguarding plans in place to address any such issues. Overall, there was sufficient evidence available to show that appropriate measures were being taken to address

any incompatibility between residents identified in the centre and reduce the likelihood of peer-to-peer incidents occurring. For example, clear guidelines in relation to positive behaviour supports was available to staff.

Staff were observed to offer assistance with intimate care to residents that required this and were seen to do so in a respectful and dignified manner. For example, staff were heard to knock on residents' bedroom doors before entering and to obtain consent from residents to carry out personal care. Bathroom doors were closed to ensure the privacy of residents.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector saw that staff treated residents with dignity and respect in the centre while the inspector was present. Staff spoke respectfully about residents and residents' information was seen to be stored in closed presses and office spaces.

Some residents' privacy and dignity in relation to their personal and living space had the potential to be impacted by the use of some shared bedrooms in this centre. However, the provider was making efforts to reduce the number of residents living in the centre with the aim that all residents would have their own bedrooms in the future. Also, the layout of the shared bedrooms was designed in a way to minimise the impact of this on the privacy and dignity of individuals.

However, the registered provider was not ensuring that each resident, in accordance with his or her wishes, age and nature of his or her disability is consulted and participates in the organisation of the designated centre. A sample of resident forum records were reviewed in one house. The folder contained guidance for staff about how to complete these meetings and provided ideas for engaging residents and involving them in this process in a meaningful way. However, the records reviewed for a six week period were seen to be repetitive, did not show evidence of meaningful consultation with residents or record residents' individual choices, and were tokenistic in nature. For example, a record completed on the day of the inspection did not make any mention that residents had been informed about the inspection. The inspector acknowledges that this information was reviewed in one house in the centre and may not be reflective of all locations.

There was also limited evidence to show that all residents had the freedom to exercise choice and control in their daily lives and this has been covered under Regulation 13: General welfare and development.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 7 OSV-0003297

Inspection ID: MON-0043486

Date of inspection: 04/07/2024

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider has assigned a dedicated Project Lead for De-Congregation within the organization for 1 year. As part of this role, the project lead will be focusing on this designated centre to ensure we meet our timelines within the partial de-congregation plan. As per the de- congregation plan, the project lead will focus on supporting 10 individuals to transition into the community by the end of 2025. A review of all resident's PCPs and goals is currently being completed by the PIC to ensure progression of these. (28.02.2025) The PIC will develop a schedule for auditing all care plans on an ongoing basis to ensure oversight. (30.09.2024) The PIC will schedule PCP training for all staff to support staff and residents in setting and achieving meaningful activities for residents. (31.03.2025) The Activation Coordinator has developed a schedule for each resident to ensure that all residents within the designated centre are afforded equal opportunities to engage in activities in their community. In addition, the PIC has weekly meetings with the staff to discuss activities that have been completed and activities that are scheduled within the week. This allows governance and oversight to ensure that all residents have the opportunity to access external and meaningful activities as per their will and preference. (09.09.2024) The PIC continues to progress the actions following the finding from the unannounced six-monthly audit. (31.03.2025)	
Regulation 31: Notification of incidents	Not Compliant

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

As per regulations, the PIC is aware that notifications are required within a specific time frame and always endeavour to achieve this. The PIC will refer to the HIQA Monitoring Notifications Handbook when reviewing incidents to ensure that all incidents are notified correctly within the precise timeframes.

From the review process, lessons learned have been taken and these will be applied going forward in thoroughly examining all incidents at the time they are reported. The PIC will continue to liaise with the DO and PPIM as appropriate, in relation to any incidents that may occur in the future to ensure timely notification of incidents to all relevant authorities. (31.07.2024)

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

All staff have been met by PIC to discuss the importance of consistently completing all documentation, including activation records and choices offered. This is an ongoing topic item on staff meeting agendas. (16.08.2024)

A review of this residents medical and nursing file has shown that this resident has not required oxygen or emergency rescue medication within the last 2 years. He was reviewed by the GP and CANP on 13/07/2024 and the oxygen has been discontinued. This now allows the resident to attend external activities without the requirement of nursing staff. He requires staff trained in the administration of buccal midazolam. The PIC has arranged training for all staff. At present half of the team is trained in the use of Buccal Midazolam with the remaining staff members booked onto upcoming training. (28.02.2024). This has had a positive impact on the resident who is now accessing the community and external activities on a regular basis.

The PIC and Activation Coordinator has completed community mapping project to provide residents with information and choice of activities and amenities in their local community. In addition to this, the PIC and Activation Coordinator liaise with the HSE community work department for information on local events and initiatives. (02.09.2024)

The Activation Coordinator has developed a schedule for each resident to ensure that all residents within the designated centre are afforded equal opportunities to engage in activities in their community. In addition, the PIC has weekly meetings with the staff to discuss activities that have been completed and activities that are scheduled within the week. This allows governance and oversight to ensure that all residents have the opportunity to access external and meaningful activities as per their will and preference. (09.09.2024)

A review of all resident's PCPs and goals in currently being completed by the PIC to ensure progression of these. (28.02.2025)

The activation coordinator vacancy currently remains, ongoing recruitment for this vacancy continues. In order to reduce the impact of this vacancy on the residents quality of life, the PIC allocates a designated staff member to oversee the activation of residents on a daily basis.

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:

All residents have now completed their annual person centred planning meeting.

All staff have been met by PIC to discuss the importance of consistently completing all documentation, including activation records and choices offered. This is an ongoing topic item on staff meeting agendas. (16.08.2024) In addition, the PIC will arrange training in documenting and recording for care assistants. (31.03.2025)

The PIC will schedule PCP training for all staff to support staff and residents in setting and achieving meaningful activities for residents. (31.03.2025)

A review of all resident's PCPs and goals is currently being completed by the PIC to ensure progression of these. (28.02.2025) The PIC will develop a schedule for auditing all care plans on an ongoing basis to ensure oversight. (30.09.2024)

The Activation Coordinator has developed a schedule for each resident to ensure that all residents within the designated centre are afforded equal opportunities to engage in activities in their community. In addition, the PIC has weekly meetings with the staff to discuss activities and goals that have been completed and those that are scheduled within the week. This allows further governance and oversight to ensure that all residents have the opportunity to access external and meaningful activities as per their will and preference. (09.09.2024)

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The provider has assigned a dedicated Project Lead for De-Congregation for 1 year within the organization. As part of this role, the project lead will be focusing on this designated centre to ensure we meet our timelines within the partial de-congregation plan. As per the de- congregation plan, the project lead will focus on supporting 10 individuals to transition into the community by the end of 2025 (31.12.2025)

The PIC has arranged staff training with the Advocacy Officer within Cope Foundation to develop the skills of staff around incorporating advocacy in to the running of the house, including communication tools and techniques for persons who are non-verbal. (13.08.2024)

The PIC will complete the residential forums with staff for three months to guide and support them in completing these. (31.12.2024) The PIC will review the residential forums on a weekly basis following this to ensure the residents continue to be consulted in a meaningful way on the running of 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.	Not Compliant	Orange	09/09/2024
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.	Not Compliant	Orange	09/09/2024
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	09/09/2024

	their wishes.			
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.	Substantially Compliant	Yellow	31/03/2025
Regulation 31(1)(f)	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: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/07/2024
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	28/02/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is	Not Compliant	Orange	28/02/2025

	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.			
Regulation 09(2)(e)	The registered provider shall 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.	Substantially Compliant	Yellow	30/09/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	31/12/2025