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

Issued by the Chief Inspector

Name of designated centre:	West County Cork 2
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	22 & 29 May 2024
Centre ID:	OSV-0003288
Fieldwork ID:	MON-0035063

About the designated centre

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

West County Cork 2 is located in a town and consists of a purpose-built one storey house. The centre has a maximum capacity of 13 residents and mainly provides full-time residential support for residents but provides respite for one resident from Friday evenings to Monday mornings and holiday periods. The residents who avail of this centre are over the age of 18, both male and female with intellectual disability and multiple and complex needs. Each resident has their own individual bedroom and other rooms in the centre include bathrooms, a kitchen, a dining room, a sitting room, an occupational area, a sensory room, an activity room and staff rooms. Residents are supported by the person in charge, staff nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 22 May 2024	09:20hrs to 19:15hrs	Conor Dennehy	Lead
Wednesday 29 May 2024	15:00hrs to 16:00hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

While the residents met during this inspection did not provide the inspector with direct feedback, positive feedback was contained within surveys completed on behalf of residents. Residents were observed to receive visits from family members during the inspection. Residents were supported in caring and respectful manner by staff members.

This centre had a maximum capacity for 13 residents with most residents residing in the centre on a full-time basis. One resident though, who lived in another centre operated by the provider on a Monday to Friday basis, attended West County Cork 2 for respite from Friday evening until Monday morning. On the day of this inspection eleven residents were present in the centre, all of whom were met by the inspector. Most of the residents did not communicate verbally and aside from one resident who appeared to take an interest in what the inspector was doing, most residents did not interact directly with the inspector. As such the inspector relied on discussion with staff and residents' family members, observations and documentation to get a sense what it was like for residents to live in this centre.

Amongst the documentation reviewed were nine surveys that had been completed for residents. Four of these surveys had been completed with the support of staff members, four with the support of family and one had been completed with the support of a friend or advocate. These surveys asked questions in areas such as staffing, residents' bedrooms, visitors and activities with the majority of responses being positive. It was noted though that in some completed surveys respondents had indicated that residents could not make phone calls in private nor could they choose what they did every day. When this was raised with management of the centre, it was indicated that these responses could be related to residents not being able to communicate verbally or respondents misunderstanding the questions.

Other than the responses to the questions asked, some surveys also contained specific comments about life in the centre. These included one survey that stated "sometimes the noise and the amount of footfall in the house can bother me" while another survey mentioned that "sometimes staffing may be an issue for outings". However, the majority of comments added to these surveys were positive. Such positive comments included "it is a nice place to live" and "the food is excellent". Staff support to residents was commented on very positively in the surveys that had been completed with the help of family members. These surveys described the staff as "exceptional" and "very friendly, caring and supportive". The staff members that were on duty during the first day of the inspection were observed and overheard to interact with residents in a caring, respectful and warm manner throughout.

For example, staff spoke respectfully of residents and were seen to knock on residents' bedrooms doors before entering. There were times though when staff members were very busy particularly early into the inspection's first day when residents were being supported to get up and to be supported with personal care. At

points during the day such staff were seen to make some time to spend some time with residents such as to engage them in table top activities or play a game of bingo. One resident spent the day in the bed and it was seen that staff, including the person in charge, took time to sit by the resident's bed. When queried by the inspector as to why this resident was in bed all day and it was indicated that the resident would become distressed if staff attempted to help them out of bed.

While some residents were taken out of the centre for a drive, using the centre's one assigned vehicle, on the first day of inspection most residents spent time in communal areas while other residents moved around the centre. One such resident came up to the inspector a number of times during the inspection and sat beside him or occasionally followed the inspector around the centre. The resident appeared content while doing so and it appeared that they were curious as to the inspector's presence. During the first day of the inspection, the inspector reviewed documentation related to this resident and it was noted that this resident had a goal to access additional day activities. It appeared though that additional staffing was needed to facilitate this. At the time of this inspection the resident was involved with an independent advocate which related to providing additional staffing support for them.

The centre where this resident lived along with their peers was observed to be reasonably presented, clean and well-furnished on the first day of inspection. It was seen that some of the flooring present was of an older presentation while some rooms were being painted on the day of inspection. As up to 13 residents could reside in the centre, the premises provided was large overall with 13 individual resident bedrooms available. Communal areas included an occupational area, a sitting room and a dining room. A kitchen was also provided which was separated from the dining room via a serving hatch which could be opened and closed via a movable shutter. The inspector was informed that this shutter was fire compliant although its presence and appearance did detract somewhat from the homeliness of the centre.

Given the size of the centre, it also provided sufficient space for residents to receive visitors in private. During the course of the first day of inspection family members of two residents visited the centre. The inspector spoke very briefly with one of these who commented very positively on the staff working in the centre. The inspector had more of an opportunity to speak with the other visiting family member as they sat with their relative who told the inspector that they visited the centre often. They also said that they could come whenever and stay for as long as they wanted. This family member praised the staff support and said that such staff were good for letting them know how their relative was doing. According to this family member, the resident was always well presented when they visited and they described the centre as "a home from home".

Soon after the inspector spoke with this family member, it was observed that another resident entered the room where the family member had been sitting with their relative. This resident was vocalising at the time and the family member left the room and centre shortly after the resident entered. It had been highlighted to the inspector that this resident could vocalise and that this was the resident's means

of communication. During the previous inspection of this centre in May 2023, there had been some indications that such vocalisations could impact others. On the current inspection it was indicated that this resident's vocalising would not impact their peers even though a risk assessments in place related to this matter indicated that environmental noise from this resident was a high risk. While there periods where no vocalising was heard during the first day of this inspection, this resident was heard vocalising intermittently with some of these periods of vocalising being noticeably loud. It was suggested to the inspector that the resident had never been as vocal as they were on the first day of inspection.

The inspector did not observe any obvious physical indication that other residents were impacted by such vocalising on the first day of inspection. It was notable though that one period of the resident vocalising took place in a bathroom that was right beside the bedroom of another resident who was resting on their bed at the time. A report of a provider unannounced visit from November 2023 suggested that the vocalising resident was adversely impacting their peers at the time of that visit. This resident also had particular preferences around the clothes they wore which may impact their privacy and dignity, such an incident happened during the inspection before being quickly redirected by staff. It was initially suggested to the inspector that such an incident had never occurred before the first day of this inspection although it was later indicated that staff had reported a similar occurrence the previous weekend. The inspector was informed referrals to an occupational therapist and a speech and language therapist had recently been made for this resident.

In summary, staff members on duty were seen to interact with and support residents in an appropriate manner during the inspector's time in the centre. Surveys reviewed and discussions with two residents' family members provided positive feedback. One resident was heard to display loud vocalisations at times during the inspection.

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

Some areas of good support to residents were found during this inspection. However, some staffing issues were evidenced during the inspection which were impacting residents. This raised a concern around the provider effectively resourcing the centre.

This centre was registered until November 2024 and had been previously inspected by the Chief Inspector of Social Services in May 2023. At the time of that inspection improvement was noted from a staffing perspective particularly relating to the

provision of three staff during the night which had been flagged as a particular area of concern in previous inspections in August 2021 and April 2022. It was also found during that inspection that the presence of multiple nursing staffing by day provided more flexibility when taking residents out from the centre for community based activities. This contributed to an overall improved level of compliance during the May 2023 inspection compared to the previous two inspections. However, that inspection did highlight that some additional staff were needed for the centre and that there had been an admission to the centre that was not in keeping with the centre's then statement of purpose. In response to this the provider indicated that an organisational review of staffing was being carried out while the provider varied its conditions in August 2023 to reflect a revised statement of purpose for the centre.

Given that the Chief Inspector would need to make a decision on whether or not to renew the registration of the centre for a further three years beyond November 2024, the current inspection was conducted to inform this decision. This inspection did find evidence of good supports in some areas, as will be discussed elsewhere in this report, but it remained the case that some additional staffing was still needed while the provision of nursing staff for the centre had reduced in the weeks leading up this inspection. Such staffing matters were impacting the provision of activities away from the centre as will be discussed further in the context of Regulation 13 General welfare and development. During the inspection it was indicated that the provider was now in the process of reviewing its staffing across all of its centres in the West County Cork region. While this was acknowledged, the findings related to staffing on the current inspection did raise a concern around the resourcing of the centre given the staffing findings during the May 2023. In addition, while there evidence of good monitoring of the centre in some areas, this inspection did find some recurrent regulatory actions in areas such as notifications and risk management.

Regulation 15: Staffing

In keeping with this regulation, staffing arrangements in this centre must be keeping with the assessed needs of the residents and the centre's statement of purpose. Some of the residents in this centre had high health needs and the statement of purpose dated July 2023, which the centre was registered against at the time of this inspection indicated that there was to be 8.5 full-time equivalent (FTE) staff nurses working in the centre which amounted to two to three nurses by day and one by night in addition to 12 FTE care assistants. However, the statement purpose present during this inspection which was dated May 2024, indicated that the staffing compliment was 7 FTE staff nurses and 14 FTE care assistants.

While the staffing levels by day and night in this statement of purpose were indicated as being the same, discussions with staff and rosters reviewed indicated that there had been times in the weeks leading up this inspection when only one staff nurse had been on duty by day. It was further highlighted that could prove challenging as two residents required the support of a nurse to leave the centre but

if only one nurse was duty, the nurse had to remain in the centre given the needs of other residents. This meant that the residents who needed a nurse to leave the centre could not do so. While it was acknowledged that there were two nurses on duty most days and a staffing review was ongoing, a draft report of a recent provider unannounced visit to the centre and discussions during this inspection appeared to suggest that consideration was being given to reducing the nursing staff compliment for the centre.

It was also apparent that given the numbers and needs of residents, some of whom required the support of two staff members for certain activities of daily living, that this was a busy centre. One staff member spoken with outlined how given the health needs of some residents, providing for such residents would taken precedence over residents who did not have such health needs. This could make it hard for the latter residents to be engaged in activities away from the centre. One such resident had a goal to participate in additional day activities. It was indicated that this resident could attend a local day services operated by the provider but needed staff to attend with them. Given the busyness of this centre, the inspector was informed that no staff could be provided to facilitate this. In addition, the existing staff compliment would also have to prepare meals for residents which took away from their time to spend with residents. This indicated that additional activation and dining staff were needed for this centre at the time of this inspection. This had been previously identified within the centre and by the May 2023 inspection.

The provision of night-time staff had been raised as a particular concern from a fire safety perspective in previous inspections in August 2021 and April 2022. Following the latter inspection the provider committed to have three staff on duty at night in the centre. This was found to be the case during the May 2023 inspection and remained the case, for the most part, at the time of the current inspection. It was highlighted to the inspector though that there had been one recent night where only two staff were on duty but this was contributed to by unexpected events. Rosters reviewed did indicated that the night-time staffing levels were in keeping with those outlined in both the July 2023 and May 2024 statements of purpose. However, the content of some fire drill records did raise a query as to whether three staff could evacuate residents in a safe time given the needs of residents particularly if such residents were in bed at night. This is discussed further under Regulation 28 Fire precautions.

Aside from such areas, under this regulation specific documentation relating to all staff working in a centre must be obtained. This documentation includes written references, full employment histories, evidence of registration with professional bodies, and evidence of Garda Síochána (police) vetting. In advance of this inspection, which was intended to be a one day inspection, the inspector requested such documentation be made available for review on the day of inspection. It was indicated that though that such documentation was not present in this centre but was held in the provider’s head offices. As such, at the invitation of the provider, the inspector attended the provider’s head office on 29 May 2024 for a brief second day of inspection to review such documentation. During this nine staff files were reviewed which for the most part were found to contain all of the required

information. It was noted though that photo identifications had expired and copies of some qualifications or training were not present in some staff files (the inspector was informed that training records could be located elsewhere). All staff files had evidence of Garda vetting in place and it was indicated to the inspector that staff were to be re-vetted every three years. However, the inspector did note that two staff member's vetting on file had exceeded this period including one that was from 2017.

Judgment: Not compliant

Regulation 19: Directory of residents

This centre had a directory of residents that was made available for the inspector to review during the first day of this inspection. It was seen that this directory contained all of the required information such as residents' names, details of their representatives or next-of-kin and the name of any authority, organisation or other body which arranged residents' admissions to this centre.

Judgment: Compliant

Regulation 22: Insurance

Documentary evidence was provided which indicated that appropriate insurance arrangements for this centre were in effect.

Judgment: Compliant

Regulation 23: Governance and management

There was an organisational structure in place for this centre which provided for lines of accountability from staff working in the centre to the provider's board of directors. There was also evidence that the centre was monitored. For example, an annual review had been conducted which assessed the centre against relevant national standards and six monthly unannounced visits by representatives of the provider had been completed that assessed the quality and safety of care and support provided. A schedule of audits had been recently introduced and was being adhered to. Despite these though some improvement was identified under this regulation. These included;

- While it was acknowledged that the residents in this centre had particular

communication needs, the annual review completed did not provide for feedback from residents.
- The action plan provided for the November 2023 provider unannounced visit did not include due dates for some actions
- Although a related action had been highlighted in the November 2023 provider unannounced visit report, a particular medicines audit had not been completed at the time of this inspection. It was indicated to the inspector that this was due to be completed by the end of May 2024.
- Despite the monitoring that was in place some regulatory actions in areas such as risk management and notifications found during the May 2023 inspection were also found during this inspection.
- The centre's statement of purpose indicated that social and community participation was to be actively encouraged and promoted for all residents living in the centre. Given this inspection's findings under Regulation 13 General Welfare and development and Regulation 15 Staffing, this did not provide assure that the centre was appropriately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

There had been no new admission to this centre since the previous inspection. However, in advance of this inspection the inspector had requested copies of residents' contracts for the provision of service to be provided. During the first day of this inspection, the inspector requested to review the contract for the resident who attended this centre for respite from Friday evenings until Monday mornings. The inspector was informed that the resident's contract was not present in the centre but might be in the centre where the resident resided on a Monday to Friday basis. After completion of the first day of this inspection, the same inspector conducted an inspection in this other centre the following day where it was found that the resident had a contract for that centre but it made no direct mention of West County Cork 2. As a result, this resident did not have a contract for provision of services in place for West County Cork 2 contrary to the requirements of the regulations. No other residents' contracts were reviewed as part of this inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had ensured that a statement of purpose was in place for this centre that had been reviewed during May 2024. This statement of purpose was found to

contain required information such as the facilities to be provided in the centre, the arrangements for dealing with reviews of residents' personal plans and the arrangements for residents to attend religious services.

Judgment: Compliant

Regulation 31: Notification of incidents

Under this regulation, any restrictive practice in use in a centre must be notified to the Chief Inspector on a quarterly basis. While quarterly notifications had been submitted for this centre in a timely manner, during this inspection it was noted that there was a rear space behind the centre that was enclosed by a locked gate. This amounted to an environmental restriction. Although the inspector was informed that this had been in place for some time, it had not been notified to the Chief Inspector as required. It was also found during the May 2023 inspection that not all restrictive practices had been notified.

Judgment: Not compliant

Quality and safety

Residents had personal plans in place that outlined their health, personal and social needs with evidence indicating that the health needs of residents were appropriately met. The provision of community activities varied while risk management was an area in need of improvement.

Under the regulations each resident in a centre should have an individualised personal plan with such plans intended to set out the health, personal and social needs of residents and provide guidance on how to meet needs. During the current inspection it was found that residents did have personal plans in place, including for the resident who attended the centre for respite. The inspector was informed though that residents did not have their personal plan available to them in accessible format. While it was indicated that this was contributed to by the particular needs of residents, having accessible personal plans in a requirement of the regulations. The personal plans that were in place were subject to annual multidisciplinary review. Records reviewed indicated that residents were supported to receive appointments from various health and social care professionals such as a general practitioner (GP) and a dentist. Within residents' personal plans it was seen that there was specific healthcare plans which outlined how resident's health needs were to be met with residents supported to undergo particular health interventions also.

Efforts were made to provide for residents' personal and social needs also. Person-centred planning was conducted to help identify goals for resident to achieve with goals including holidays and decorating residents' bedrooms. Evidence was provided that such goals were progressed. Records reviewed also indicated that residents were involved in various activities within the centre such as watching television, listening to radio and bingo. Multiple activities within the centre tended to be recorded daily but activities away from the centre were noticeably less regular and were at times repetitive. For example, drives appeared to be the dominant external activity for some residents while one resident was seen to go on external activities. While it was acknowledged that the residents in this centre had particular needs, and there was some external activities taking place such as meals outs, the finding in this area appeared impacted by staffing matters as referenced earlier in this report. Risk assessments related to such matters indicated that additional activation staff was an additional control measure required to mitigate associated risks. The same additional control measures were noted during the May 2023 inspection but had not been addressed since then. This raised concerns around the management of risk in the centre.

Regulation 11: Visits

Given the size of the centre, there was space available for residents to receive visitors in private in a room other than their bedrooms if they wished to do. Surveys reviewed during this inspection raised no issues around visiting and during the first day of inspection, the family members of two residents were seen to visit. The inspector spoke with one of these family members who informed the inspector that they visited the centre often and could come whenever and stay for as long as they wanted.

Judgment: Compliant

Regulation 13: General welfare and development

Although multiple internal activities tended to be recorded daily, activities away from the centre were noticeably less regular and were at times repetitive based on records reviewed. For example;

- Drives were the only or most dominant external activities recorded for some residents. For example, in February 2024 for one resident it was seen that the only activity they did away from the centre was drives.
- There were periods when external activities for residents were limited. These included one resident not recorded as having participated in any external activity for 12 days in May 2024 up until the first day of this inspection while a resident was not recorded as having done any external activity between 10

February 2024 and 1 March 2024.
- On two occasions in 2024, "hospital/appointment" was listed as an external activity that a resident did.

While it was acknowledged that the residents in this centre had particular needs and that there were some arrangements for external activities, the findings of this inspection indicated that residents were not consistently supported to avail of meaningful community based activities.

Judgment: Not compliant

Regulation 17: Premises

While the presence of shutter between the kitchen and dining area, did detract from the homeliness of the premises provided, overall, the premises was observed to be reasonably presented, clean and well-furnished on the first day of inspection. There were 13 individual resident bedrooms available for residents along with communal space that included a sitting room, a dining room, an occupational room, an activities room and a sensory. Bathrooms facilities and staff rooms were provided also while no issues were observed relating to storage. Some hoists that were present in the centre were noted to have been serviced within the past 12 months to ensure that they were in proper working order.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had put in place a risk management policy and in keeping with this a risk register for the centre was in place. This outlined risks that related to the centre overall and was indicated as last having been reviewed in December 2023. Risk outlined in this register had corresponding risk assessments in place (some of which had been reviewed in 2024). These risk assessments described the relevant risks, outlined existing controls on how to mitigate the risks and additional control measures that were required to reduce likelihood of the risks occurring. Within the risk register and related risk assessments were some higher rated risks for areas such as welfare of residents, food preparation/hygiene and work related stress (using a risk matrix these risks were rated as orange or red with red being a high risk).

Such higher rated risks outlined additional controls that were needed to mitigate these risks. These included dedicated kitchen staff and activation staff being needed. While there was indications that such matters were being reviewed and it indicated that a staffing review was ongoing at the time of this inspection, the same

additional control measures had also been seen as being required during the May 2023 inspection. Given that they remained as additional controls and such risks remained rated as higher risks, this did not provide assurance that the provider had appropriately responded to the identified risks since the May 2023 inspection. In addition, despite there being open red rated risks in the centre' risk register, the inspector was informed that none of these high risks had been escalated within the provider. The inspector did note though that the risk ratings applied to some risk assessments required review to ensure accuracy. While it was indicated that the provider's health and safety officer was due to visit the centre by the end of June 2024 to review such matters, a similar issue had also been identified during the May 2023 inspection.

One of the red rated risks on the centre's risk register was for environmental disturbance. This related to the vocalisations of one resident as referenced earlier in this report. An additional control outlined to mitigate this risk was for an assessment to be carried out for the resident. However, the risk assessment indicated that this was awaiting documentation and it was unclear when the assessment would actually be carried out. In addition, given the regularity at which this resident could vocalise, it was indicated to the inspector that all had residents had been individually risk assessed around the impact from such vocalising. Risk assessments for four residents were reviewed and it was found that two of these residents did not have a relevant risk assessment in place in this area. This included the resident whose bedroom was right beside a bathroom where their peer was vocalising as referenced earlier in the report. For the two residents who did have a risk assessment in place related to environmental disturbance, it was seen that the risk had been rated as an orange risk.

Although during this inspection it was indicated to the inspector that the vocalising resident did not impact their peers, given the content of relevant risk assessments that were in place coupled with the observations of the current inspection, the May 2023 inspection and the provider unannounced visit in November 2023, further risk assessment was needed in this area. Any additional control measures outstanding would also need to be implemented in a timely manner to mitigate the risks involved.

Judgment: Not compliant

Regulation 28: Fire precautions

Records provided indicated that staff working in the centre had completed relevant fire safety training. Fire safety systems were present in the centre such as a fire alarm, emergency lighting and fire extinguishers with such systems subject to maintenance checks to ensure that they were operating correctly. Fire drills were also occurring regularly in the centre, which are important to ensure that staff and residents are aware of what to do in the event of an evacuation being required. When reviewing drills records it was noted that all fire drills conducted since the May

2023 stated that three minutes was a safe evacuation time. The majority of these drills had a recorded evacuation time of under three minutes but two drills indicated an evacuation time over three minutes. When this was queried it was verbally indicated to the inspector that four minutes had been deemed a safe evacuation time although a fire safety report from May 2022 provided previously to the Chief Inspector for this centre recommended evacuation times of under three minutes.

Although the drills that had been conducted were done at varying times, it was seen that that majority were done between 11:30am and 12:30pm or 3:30pm to 5:30pm. Some of the drills completed were indicated as involving three staff which would be the minimum of amount of staffing working in the centre at night. However, from the drills records reviewed it was not clear if such drills reflected times or scenarios when residents would be in the bed. Given the concerns that had been raised in previous inspections in August 2021 and April 2022 about the provision of night-time staff from a fire safety perspective, the provider would need to ensure that fire drills completed took account of night-time scenarios to provide assurance that residents could be evacuated in a safe time. This was particularly important given that, based on documentation provided during this inspection, eight residents living in this centre required the support of two staff to evacuate.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had individualised personal plans which set out their health, personal and social needs. These personal plans were subject to an annual multidisciplinary review while a person-centred planning process was followed to involve residents or their representatives in their personal plans. As part of this process, a person-centred planning meeting where residents' lives were discussed and goals identified for them. While it was acknowledged that the residents in this centre had particular needs, their personal plans were not available to them in accessible format as required under the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had specific healthcare plans in place within their personal plans outlining the supports they needed for identified health needs. There was evidence of residents' health needs being monitored such as through annual health checks. Records reviewed indicated that residents were supported receive appointments from various health and social care professionals such as a GP and a dentist while health interventions such as vaccines were also facilitated. Hospital passports were

also available for residents if they needed to be transferred to hospital with such documents outlining key information about residents' health needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Based on records provided, staff had undergone relevant training in positive behaviour support. Processes were in operation for any restrictive practices in use to be assessed and reviewed. It was noted though that a rear space behind the centre that was enclosed by a locked gate had not been recognised as an environmental restriction.

Judgment: Substantially compliant

Regulation 8: Protection

For any safeguarding notifications that had been submitted to the Chief Inspector since the May 2023 inspection, documentary evidence was provided that they had been screened in accordance with relevant safeguarding policies and that measures taken in response to these particular incidents had been effective. Staff members working in the centre had been provided with relevant training. Guidance on supporting residents with their intimate personal care was present in the residents' personal plans.

Judgment: Compliant

Regulation 9: Residents' rights

Where any rights restrictions were identified these had been documented and reviewed as such. When reading records related to these it was seen that a rights restriction had been identified for one resident related to transport in November 2023. The centre had access to one vehicle only and it had been identified that the resident involved could request to leave the centre for drives but could not do so if the centre' vehicle was out with other residents. While this was not highlighted as being a significant issue during this inspection, the documentation reviewed related to this matter indicated that this rights restriction could be discontinued by the provision of a second vehicle. The inspector was informed that a request for a second vehicle had been made internally within the provider but that there had been

no response to this.

Aside from this, some positive examples of the rights of residents being protected and promoted were seen during this inspection. These included;

- Staff supporting and speaking of residents respectfully. This included staff knocking on residents' bedroom doors before entering.
- Attempts made to give residents information through resident forums.
- A resident being supported to engage with an external independent advocate with residents also having access to an advocate within COPE Foundation.

Over a period time, the provider's internal advocate had supported the resident who attend this centre for respite to express their will and preference about in their living arrangements. In doing so, the resident expressed their desire to reside full-time in the centre where they lived Monday to Friday rather than having to attend West County Cork 2 for respite. It was noted though that staff in both West County Cork 2 and the centre where they lived Monday to Friday (which was inspected the day after the first day of this inspection by the same inspector), indicated that the resident was happy going to respite in West County Cork 2. While the resident was not met on either inspection, a survey completed on behalf of the resident by a family member indicated similar (as seen during the inspection of the other centre involved).

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	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for West County Cork 2 OSV-0003288

Inspection ID: MON-0035063

Date of inspection: 22/05/2024 & 29/05/2024

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
• A member of the HR department is responsible for ensuring that all employees Garda vetting is in date. Going forward the PIC will also maintain a local database pertaining to all staff's Garda vetting status. This will enable a more robust system for the PIC / management team to have assurances regarding vetting renewal for all staff working in the designated centre in conjunction with the HR department.
• An internal review has been completed pertaining to staff numbers and skill mix in the designated centre. As per the review, optimal staff numbers by day are 6 (this includes 2 staff nurses with a minimum requirement of 1 staff nurse per day. CNM2 is also onsite Monday to Friday to support with nursing duties). Optimal staff numbers by night is 3 (with a minimum requirement of 1 staff nurse by night). The Person in Charge will implement governance protocols in relation to roster planning including regularly reviewing rosters and making necessary adjustments based on feedback and changing needs, using metrics to evaluate the effectiveness of rosters such as absenteeism rates, adhering to maximum leave protocols for staff nurses and care assistants and planning for contingencies in the event of unexpected absences or sudden changes in demand.
• Staff will be identified on the roster on a weekly basis to take up responsibility for coordinating residents' activities.

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</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Management systems / governance protocols are in place in the designated centre to ensure that the service provided is in line with regulatory requirements. These include</td></tr>
</table>

but are not limited to; local and regional governance protocol (deputizing arrangements in the absence of the PIC), protocol for staff induction, protocol for auditing, quality health and safety committee monthly meetings, safeguarding protocols and communication and handover of information protocol. Protocols in place are reviewed regularly by management team and discussed with staff at team meetings, weekly handovers etc.

• The PIC will ensure that specific timelines for actions identified following provider unannounced inspections are included in the final draft of the report so that progress on identified actions can be monitored ongoing to completion as part of local monthly Quality, Health and Safety committee meetings.

• The PIC will ensure that the annual review carried out in the centre will provide for feedback from residents.

• A medication audit was completed by Assistant Director of Nursing on 06/06/2024. The report was given to Person in Charge and actions identified for completion. The PIC will complete actions as per schedule and ensure that medication audits are completed in line with organizational audit protocol and schedule (or sooner if required).

• The centre's risk register and risk management procedures were reviewed by the Person in Charge and Health and Safety Officer on 24/06/2024. Recommendations have been given to the Person in Charge by the Health and Safety Officer in relation to updating the centre's risk register and individual risk assessments for residents. The Person in Charge will action recommendations as prescribed by 31st August 2024.

• As per the centre's local and regional governance protocols, notifications will be submitted to the Chief Inspector in line with regulatory requirements within the specific timeframes indicated. The PIC will arrange for a peer review / audit of all restrictive interventions in place in the designated centre, to provide assurances that all restrictive interventions in place are implemented in line with organizational policy, subject to regular review and submitted to the Chief Inspector on a quarterly basis as per regulatory requirements.

• An internal review has been completed pertaining to staff numbers and skill mix in the designated centre. As per the review, optimal staff numbers by day are 6 (this includes 2 staff nurses with a minimum requirement of 1 staff nurse per day. CNM2 is also onsite Monday to Friday to support with nursing duties). Optimal staff numbers by night is 3 (with a minimum requirement of 1 staff nurse by night). The Person in Charge will implement governance protocols in relation to roster planning including regularly reviewing rosters and making necessary adjustments based on feedback and changing needs, using metrics to evaluate the effectiveness of rosters such as absenteeism rates, adhering to maximum leave protocols for staff nurses and care assistants and planning for contingencies in the event of unexpected absences or sudden changes in demand.

• Staff will be identified on the roster on a weekly basis to take up responsibility for coordinating residents' activities.

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 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

• A Short Breaks Contract / Service agreement has been developed as part of Cope Foundation's Standard Operating Procedures for all Short Breaks / Respite services. The contract has been provided to the Person in Charge and Person Participating in Management. The Person in Charge will sit with the individual and their chosen representative to explain the agreement and discuss any queries they have in relation to the agreement. The person's signed contract / service agreement will be kept onsite in the person's file for review and regulatory purposes. The person will receive a copy to retain for themselves / their representative also if they choose.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
PIC will ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre; any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Right's Restrictive Practices were reviewed by the PIC. Residents had not accessed the locked gate in a rear space behind the centre and following consultation with the Right's Restriction committee and in order to reduce restrictions in the centre the padlock was removed from this gate. Risk Register updated to reflect.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Staff will be identified on the roster on a weekly basis to take up responsibility for coordinating residents' activities. The will and preference of each residents, guides their chosen activity. These activities will be documented and linked back to the residents Personal Goals/Plan.

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:
• The centre's risk register and risk management procedures have been reviewed by the Person in Charge and Health and Safety Officer on 24/06/2024. Recommendations have been given to the Person in Charge by the Health and Safety Officer with regards to updating risk register, individual risk assessments and escalation of risks as per organizational policy. The Person in Charge will action recommendations as prescribed by the Health and Safety Officer.
• The Person in Charge will complete an internal review of specific risks pertaining to residents and the impact of the vocalizations of another resident. As part of the internal review, the Person in Charge will outline in detail all existing control measures currently

being implemented and suggested additional controls that may be required in order to reduce the risk and impact on other residents living in the designated centre. Information from the internal review will inform risk assessments on environmental disturbance for any individual impacted by the resident's vocalizations.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Person in Charge will ensure that fire drills are completed at varying times to allow for minimal staffing numbers and scenarios where residents are in bed.

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 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC will ensure that the residents will have their personal plans in accessible formats.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Review of Right's Restriction (ref side gate) has taken place. Guidance was sought from the providers Right's Restriction Committee. The lock has since been removed. Risk Register has been updated to reflect same.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
PIC will explore all options with other local Centre's regarding access to vehicle's especially at weekends and holiday times.

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)(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	30/04/2025
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 their wishes.	Not Compliant	Orange	30/04/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	30/09/2024

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	30/09/2024
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/07/2024
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.	Substantially Compliant	Yellow	31/12/2024
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	Not Compliant	Orange	30/09/2024

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/08/2024
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/07/2024
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the	Not Compliant	Orange	31/07/2024

	terms on which that resident shall reside in the designated centre.			
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	31/07/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	31/07/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/07/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is	Not Compliant	Orange	31/07/2024

	provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	31/08/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	31/07/2024
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her	Substantially Compliant	Yellow	31/08/2024

	disability has the freedom to exercise choice and control in his or her daily life.			