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:	East County Cork 2
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	09 January 2023
Centre ID:	OSV-0003290
Fieldwork ID:	MON-0029771

About the designated centre

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

This is an adult short break / respite service for people in receipt of full-time day services operated by the same provider. Residents have an intellectual disability and / or are autistic. The designated centre can accommodate up to six residents at any one time. The premises is located in a large coastal town adjacent to facilities and amenities. The premises comprises two semi-detached houses over two floors, which presents as one large house. There is a kitchen / dining room and two living room spaces. There are five bedrooms upstairs, and one wheelchair-accessible bedroom downstairs. A respite / short breaks service was not provided during the initial two years of the COVID-19 pandemic. Instead it was a dedicated isolation unit to be used if, and when, it was needed. The short breaks service resumed in the centre in June 2022.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	0

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
Monday 9 January 2023	09:35hrs to 18:30hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

As was identified during the previous inspection of this centre, completed on behalf of the Chief Inspector of Social Services (the Chief Inspector) in December 2021, there was not sufficient management oversight in this centre to ensure compliance with the regulations. This shortcoming and its impact had been highlighted in the report written following that inspection and again in an unannounced visit report completed by representatives of the provider in July 2022 and in the annual review completed in September 2022. The governance arrangements in place had not ensured that the compliance plan submitted by the provider to the Chief Inspector had been implemented, or that the service was operated in keeping with the requirements of the regulations in advance of, or since, the resumption of the short breaks service in the centre. These repeated findings will inform the Chief Inspector's response to provider's current application to renew the registration of this centre.

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

The centre is a two-storey house located in a coastal town in county Cork. The centre was registered to provide a residential service to six adults at any one time. A short breaks service was provided to adults who attended day services operated by the provider. This service was suspended in March 2020 so that the designated centre could be used, if needed, for isolation purposes during the initial stages of the COVID-19 pandemic. An application was submitted to the Chief Inspector to resume providing a short breaks / respite service in the centre in November 2021. Following an inspection completed on behalf of the Chief Inspector in December 2021, the provider's application was granted in April 2022.

The inspector was informed that the short breaks service had resumed in the centre in June 2022. As planned, this was a phased reopening. Initially breaks were offered to residents on their own or by grouping according to the day service they attended. This was to reduce the risk of spreading any transmissible infections, including COVID-19. While it was hoped that the phased reopening would provide the service seven days a fortnight, this had not been possible initially due to staffing shortages. Two more staff had been assigned to the centre in December 2022 and as a result it

was planned, following this inspection, to offer a two-night and three-night stay in the centre on alternate weeks. Additional staff recruitment was planned. Until this was in place, the service could not operate at full capacity. 22 residents stayed in the centre in 2022, staying either on their own or with others in groups of two or three. Prior to the COVID-19 pandemic over 60 residents had regularly availed of this service. Management advised of their intention to resume a seven days a week service, operating at full capacity, as soon as staffing resources allowed.

This was an announced inspection. On arrival the inspector was greeted by the proposed person in charge and the person participating in management. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and staff adhered to these throughout the inspection. There were no residents staying in the centre at the time. Following a Christmas break, the short breaks service was due to be provided for the first time in 2023 later that week. That morning management were not able to confirm if more than one resident was due to stay in the centre that week. The proposed person in charge advised that they had informed some residents and their relatives of the inspection and that none had expressed a wish to speak with the inspector.

There were five bedrooms for residents upstairs and one downstairs. Bedrooms were clean, had some artworks on display, and were fitted with units for residents to store their belongings. Some had a single bed, while others had a double bed. A profiling bed was in place in the downstairs bedroom. Management advised that this downstairs bedroom facilitated residents with mobility support needs to stay in the centre. Since the December 2021 inspection, the plan to use a former staff bedroom as a resident bedroom had been implemented. A smaller room, previously used as a bedroom, was now available to residents as an additional recreational space or activity room. At the time of this inspection it was furnished with a table and chair.

Downstairs, on one side of the house there was the staff office, one resident bedroom and a bathroom. On the other was a large kitchen, a large living room, a utility room, a toilet, and another communal sitting room. The kitchen and communal areas were decorated in a homely manner. The notice board in the kitchen displayed information regarding complaints, food safety, and coughing etiquette. Photographs were also available to support residents' communication regarding the food and activity choices available. The kitchen was observed to be clean, well-equipped, and well-organised. There were photographs on display throughout the living room. The room also had a wall-mounted television, a large couch, a bean bag, and three comfortable chairs. There were also soft furnishings available. The smaller sitting room, called the music room, was also fitted with a wall-mounted television, a couch, and a chair.

As was identified in the two previous inspections of this designated centre, it was still the case that many walls in the centre needed to be repainted. This was most obvious where fittings and fixtures had been removed. Painting was also required in communal areas, the utility room, and in some of the bedrooms. When asked about this, management advised that painting had been requested but due to the large number of similar requests from other centres operated by the provider and the

delays in meeting these demands due to public health restrictions, there was still no timeline for this work to be completed. It was also noted that some areas in the centre required more intensive cleaning. These included some seals around window frames and some grouting in the bathroom. Possible damage to the ceiling area was noted in the utility room. Management submitted a request for the utility room ceiling to be reviewed during the inspection.

At the time of the last inspection in December 2021 there was a noticeable draught in the entrance hall of the centre. Measures had since been put in place to address this. In the most recent annual review of the centre, completed by a representative of the provider, there had been reference to works required in the outside area behind the house. It was evident on the day of inspection that this had been followed up. When walking around the centre it was identified that the floor plans submitted to support the application to renew the registration of the designated centre were not accurate. The provider was asked to submit up-to-date and accurate plans.

As well as spending time in the centre and speaking with management staff, the inspector also reviewed some documentation. Documentation reviewed included the most recent annual review, and the reports written following the two most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. The inspector also looked at staff rosters, staff training records, the directory of residents, the centre's risk register, COVID-19 information and contingency plans, fire safety documentation, the centre's statement of purpose, and the guide prepared for residents. A sample of the assessments and personal plans of the 22 residents who had stayed in the centre in the previous seven months were also reviewed. As was identified previously, resident-specific documentation had not been reviewed or maintained in many years despite these residents recently staying in the centre. It is a requirement of the regulations that a comprehensive assessment of the health, personal and social care needs of each resident is completed at least annually and that this assessment is used to prepare a personal plan which is subject to review, at least annually. It was also evident that there was poor record keeping in the centre which indicated that the provider's own policies in the areas of medication management and personal possessions were not implemented.

As this inspection was announced, feedback questionnaires for residents and their representatives were sent in advance of the inspection. Four questionnaires were returned to the inspector. The feedback provided was positive with residents reporting that they enjoyed going for walks, to the shopping centre, and out for meals while staying in the centre. Other activities residents enjoyed included watching television and films, dancing, and swimming. Respondents were also positive about the staff team with one describing them as 'the best'. Another reported that they wouldn't change anything about the centre.

The inspector also reviewed the feedback from some residents' relatives outlined in the annual review of the centre completed in September 2022. The feedback received was mixed. A number of respondents were critical of the communication

with them. One person described feeling ignored during the pandemic when the centre was closed. When the short breaks service resumed, the notice given in advance of stays was described as too short and the time taken to confirm requested stays as too long. When this was raised with management by the inspector they advised that in addition to staffing shortages in the centre, there had also been administrative staff shortages. The proposed person in charge had arranged a meeting later that week with the provider's short breaks coordinator to plan stays for the first quarter of the year. Management advised that it was expected that the recent appointment of the proposed person in charge, who worked in this centre only, would improve communication with residents and their families. Two respondents also highlighted that things had changed for their relative in the two years since they had last stayed in the centre and that they had no way of passing this important information on to the staff team. As was outlined already, there was no evidence that any changes to residents' support needs had been documented in the centre.

There was also positive feedback gathered as part of the annual review. One respondent expressed relief that the centre had reopened and hoped that it would return to operating on a full-time basis. Respondents stated that their relatives enjoyed going to the centre and enjoyed the activities, including those in the local community, available to them. The staff team were described as 'so nice', 'kind' and 'welcoming' with one respondent mentioning that staff cook their relative's favourite meals. The facilities were also praised and reported to be warm and homely.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

A new management structure had been introduced to this centre less than a month prior to this inspection. While evidence on the day suggested that this would significantly improve the governance and management arrangements in place, as they had only recently taken up the role the effects of this appointment were yet to be seen in the centre. As a result the findings of this inspection highlight the impact of the ineffective arrangements that had been in place since the last inspection, during which time the short breaks service had resumed.

There was a clearly-defined reporting structure in place that identified lines of accountability and responsibility. Care staff reported to the proposed person in charge, who reported to the person participating in management. The person participating in management had fulfilled the person in charge role in the centre from November 2021 to December 2022 while also holding a senior management role with the provider. The findings of this inspection indicated that their remit was

too broad to provide the management presence and oversight required to ensure the service provided in the centre met the requirements of the regulations. These findings are outlined throughout this report.

Four weeks prior to this inspection the provider notified the Chief Inspector of a change to the person in charge. This person was assigned to work in this centre only, was supernumerary, and was employed on a full-time basis. This person had previously fulfilled the person in charge role in the centre in late 2018 and again from December 2019 to March 2021. For this notification to be progressed, prescribed information, as outlined in the regulations was required. As some of this was outstanding, at the time of this inspection this person remained the proposed person in charge.

From speaking with this person, it was clear that they had systems, processes and procedures that they wished to re-introduce to the service. These included team and one-to-one staff meetings, family forums, assigning a keyworker to each resident, an audit schedule, and the use of templates to record specific information when residents arrived, during their stay, and when they left the centre. They had also identified some of the provider's policies, including the one regarding medication management, to review with the staff team as a priority. The proposed person in charge had read the most recent reports completed on behalf of the Chief Inspector and by representatives of the provider and had used these to begin to generate a plan to improve the quality of the service provided in the centre. They had also arranged to meet with the provider's short breaks coordinator to schedule stays in the centre, and with the managers of the various day services residents attended to get the most up-to-date information regarding residents' support needs. Multidisciplinary reviews of residents' personal plans were also scheduled for February and March 2023. While these proposed actions, if implemented, suggested that the centre may come into compliance with the regulations in the future, the findings on the day of this inspection indicated high levels of non-compliance.

The provider had completed an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in September 2022 and involved consultation with a sample of relatives of residents who had stayed in the centre since it re-opened in June 2022. There was no consultation with residents, as is required by the regulations. The feedback received at this time was outlined in the opening section of this report. An unannounced visit had taken place in December 2021 and again in July 2022. A number of the areas identified as requiring improvement in these reports were consistent with those identified during the December 2021, and again in this, inspection completed on behalf of the Chief Inspector. While some matters identified by the provider's representatives had been addressed, such as maintenance work in the outside areas and the removal of an oxygen cylinder, actions to ensure compliance with a number of key regulations had not been completed. These included improved management oversight, provision of written service agreements to residents, staff training in infection prevention and control, notifying the Chief Inspector of incidents as required by the regulations, assessment of residents' needs prior to returning to stay in the centre, revision of the personal plans of all residents staying in the centre, and the implementation of

quality improvement plans, including the compliance plan submitted to the Chief Inspector in January 2022.

The inspector reviewed the findings of this inspection with the compliance plan submitted by the provider in January 2022. The actions outlined regarding six regulations had not been completed as outlined, 12 months later. These included updating residents' personal plans and records before the service reopened, completing all maintenance and repair works, and ensuring staff had completed mandatory training. These and other findings indicated that the governance and management systems in the centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

In advance of this inspection, the inspector reviewed any notifications that had been submitted regarding this designated centre to the Chief inspector. Only one notification had been submitted and this was not sent within the required timeframes. During the inspection, as was also the case in December 2021, it was identified that a restrictive procedure used in the centre had not been notified, as is required by the regulations.

The staff roster was appropriate to the operation of the centre at a reduced capacity. However, it was not clear when reading the roster when staff were working in this centre or when they had been redeployed to work elsewhere. Management addressed this during the inspection. As outlined previously there were not sufficient staffing resources available for the centre to provide a short break breaks service to six residents, seven days a week.

Training records were available for the proposed person in charge and the four staff working in the centre. On review, it was identified that some staff required training in some of the areas identified as mandatory in the regulations. One staff required training in fire safety. As was found in December 2021, staff required training in the management of behaviour that is challenging including de-escalation and intervention techniques. The provider offered online fire training and the staff member had been asked to complete this. All of the team were booked to attend positive behaviour support training in the coming weeks. One staff required training in the safe administration of medicines, including emergency medications. Management assured the inspector that this training was scheduled and that this resident always worked with a colleague who was fully trained in these areas. Training records in areas of infection prevention and control (IPC) including hand hygiene were not available. Management advised that plans were underway for each staff member to have their practical hand hygiene skills assessed, however there were no dates confirmed for this to take place.

The inspector reviewed the directory of residents. While this contained the majority of the required information, as outlined in Schedule 3 of the regulations, for most residents the date they first stayed in the designated centre was not recorded. It is also a requirement of the regulations that the dates during which the resident was not residing at the centre is recorded. As is common in a short breaks or respite service, the provider instead had recorded the nights that residents did stay in the centre. In the course of this inspection it was identified that this information was

recorded in three separate documents, each with their own purpose. On review by the inspector it was identified that these records were not consistent with each other. On further review with the centre's management team, it was identified that there was at least one error in each document. It was therefore difficult to determine the number of nights each resident had spent in the centre in 2022.

The centre's statement of purpose had been submitted to the Chief Inspector in advance of this inspection to support the application to renew the registration of the centre. This is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. A more up-to-date version of this document was available in the centre. This document met the majority of the requirements of the regulations. Some revision was required to ensure that the information included was accurate and reflective of the type of night staffing currently provided in the designated centre and that additional information regarding the emergency procedures, specifically if the centre were to become uninhabitable were included. It was also required to outline the provider's policy regarding emergency admissions to this centre and to ensure that the room labels were consistent with those on the revised floor plans to be submitted. Clarity was also required regarding the fees to be charged to stay in the centre.

Registration Regulation 5: Application for registration or renewal of registration

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

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was appropriate to the operation of the designated centre at reduced capacity. There were planned and actual staff rotas in place. Staff personnel files were not reviewed.

Judgment: Compliant

Regulation 16: Training and staff development

As was found on the last inspection staff had not recently attended all training identified as mandatory in the regulations. This was planned within weeks of this

inspection.

Judgment: Substantially compliant

Regulation 19: Directory of residents

Not all information, as specified in Schedule 3 of the regulations, was included in the directory of residents.

Judgment: Substantially compliant

Regulation 21: Records

Records were poorly maintained in the centre. Among those not documented were the date on which any money was returned to the resident and written acknowledgement of the return of this money. In many instances there were no records available regarding residents' recent stays in the centre. The dates residents stayed in the centre were not accurately recorded.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider ensured that insurance against injury to residents was in place.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not adequately resourced the designated centre. The management systems in place did not ensure sufficient presence or oversight to ensure that the service provided was safe, appropriate to residents' needs or effectively monitored. The annual review did not provide for consultation with residents. Plans had not been put in place to address concerns identified in the annual review or during unannounced visits to the centre to monitor the safety and quality of care and support provided. The provider had not put arrangements in place to facilitate staff to raise concerns about the quality and safety of the care and support provided. The

provider had not implemented the compliance plan previously submitted to the Chief Inspector.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Residents who had stayed in the designated centre since June 2022 did not have a written service agreement that outlined the terms on which a resident would stay in the centre, the support, care and welfare of the resident, the services to be provided, and, where appropriate, the fees to be charged. The provider had drafted an agreement which they planned to issue in the coming weeks.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure all information was up to date and accurate, including the night time staffing arrangements and the room descriptions. Additional information was required regarding the emergency procedures in place, the provider's policy regarding emergency admissions to this centre, and clarity regarding the fees to be charged to those who stayed in the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

One notification was submitted outside the timeframe specified in this regulation. All restraints used in the centre had not been notified to the Chief Inspector, as required.

Judgment: Not compliant

Quality and safety

Although some residents reported that they enjoyed their recent stays in the centre

and members of the staff team had supported their successful return to the centre, the lack of implementation of the provider's own policies and procedures, and the absence of management systems to ensure the service provided was effectively monitored, resulted in poor compliance with the regulations regarding quality and safety.

Prior to June 2022, residents had not stayed in this centre for over two years. To support residents to get to know new staff prior to staying in the centre, staff spent time with some residents in their day services. This also supported staff to get to know the residents and an understanding of their support needs. Management also advised that residents who attended a nearby day service had gone to the centre once during the day for tea to reacquaint themselves with the building.

Where records were available, it was documented that residents enjoyed watching television and DVDs while in the centre and also went out for dinner, for a coffee, to the cinema, and for walks during their stays.

The inspector reviewed a sample of the assessments and personal plans of residents who had stayed in the centre since June 2022. Healthcare and other assessments were either outdated or blank. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and preferences, personal care, healthcare and other person-specific needs such as mealtime support plans. As was found in the December 2021 inspection, many documents were not dated. However from reviewing the information, including the documents that were dated, it was clear that these had not been updated since the previous inspection. Management advised that when staying in the centre, residents' day service files were brought to the centre. However, the information in these files was not specific to the care and support to be provided in the designated centre. In the compliance plan submitted to the Chief Inspector in January 2022, the provider stated that the plans of residents due to stay in the centre had been prioritised to be updated first and that current information would be in their personal plan on their return to the centre. Management acknowledged that this had not been completed.

Residents' healthcare management and personal development plans had also not been reviewed in recent years. When the inspector asked to see the protocols to be implemented should a resident require the administration of a prescribed emergency medication, management advised that this protocol arrived with the resident. This arrangement did not support staff to familiarise themselves with the plan in advance of the resident's stay in the centre. Some residents' plans included a summary document to be brought with them should they require a hospital admission. These were not dated and were also found to have not been updated. For example, one resident now regularly used medical equipment while asleep however this was not referenced in this document.

Residents' individual risk assessments, filed in with their personal plans, had not been reviewed in over two years. However the centre risk register had been revised recently. The inspector read this and identified that not all documented control measures, such as specific staff training, were in place. The risk regarding the small

staff team available and how this impacted on the ability to provide the short breaks service had also not been assessed. The proposed person in charge committed to following up on these matters.

The inspector reviewed the medication management processes in place in the centre. As there was no-one staying in the centre at the time of the inspection it was not possible to review any prescriptions or medication administration records. Management advised that these returned home with each resident following their stay in the centre. The provider's policy outlined the requirement for regular medication management audits. None had taken place in the centre since the short breaks service had resumed in June 2022. The most recent medication management audit available in the centre was dated February 2020. As was found in an unannounced visit in July 2022 and again in the annual review completed by representatives of the provider in September 2022, the signature bank for those administering medicines had not been updated in many years and did not include all members of the current staff team. Management showed the inspector the storage facilities available. Medicines were to be stored in a secure, dedicated area of the staff office, with six separate designated storage spaces. The proposed person in charge explained that as the centre was not operating at full capacity, one of these areas could be used to separately store medicines that were out of date or were required to be returned. The inspector was informed that records documenting the receipt and return of residents' medicines were to be signed by two staff. Management advised that on some occasions a staff member from a day service may sign these documents with one of the centre's staff team. Of the sample of records reviewed by the inspector, all records were either blank, or if completed, had not been signed by more than one staff member.

The inspector reviewed the processes and procedures in place to protect residents against infection, including COVID-19 and other common respiratory illnesses. There were supplies of personal protective equipment (PPE) available. Information regarding hand hygiene, cough etiquette and other measures were on display throughout the centre. The inspector reviewed a first aid kit. This did not contain all of the required items. The proposed person in charge advised that they would contact the pharmacy to arrange this in advance of residents staying in the centre. Information, including the latest public health guidance, regarding COVID-19 was in place. A contingency protocol had been developed to implement in the event of a suspected or confirmed case. This plan required review to ensure that it reflected the current management structure, the revised notification requirements, and the pathway to be followed in this centre as opposed to other full-time residential services operated by the provider. The provider had also completed a self-assessment regarding preparedness planning and infection prevention and control (IPC) assurance. While this had been recently reviewed and included actions to be completed, the absence of staff IPC training records was not identified.

As outlined previously, the centre was observed to be generally clean on the day of inspection. Some areas requiring maintenance were referenced in the opening section of the report. In addition some damaged surfaces were also observed. These included the end of the kitchen counter and some of the bedroom storage units. Some rust was also observed on fittings in a bathroom. It would therefore not be

possible to effectively clean these surfaces. The utility room was well-organised. A washing machine and tumble dryer were stored in this room. The labelled baskets available indicated that systems were in place ensure that clean and unclean laundry were kept separate. Posters on display indicated that a colour-coded cleaning system was in use in the centre whereby certain coloured equipment was used in specific areas to reduce the risk of cross contamination. Equipment was stored according to this system. The walls in this room were marked by some of this equipment and needed to be painted. As outlined in the opening section of this report, some damp was observed on the ceiling of this room. It was also identified that the self-closing mechanism on the door was not fully closing the door. If this door was not fully closed, it would not serve as an effective containment measure in the event of a fire. Management requested a review of the door closer and ceiling during the inspection.

Systems were in place and effective for the maintenance of the fire detection and alarm system, fire fighting equipment, and emergency lighting. Regular drills had taken place since the service resumed in June 2022 and were completed within time frames assessed as safe by the provider. A drill in night-time conditions was scheduled for later that week.

Regulation 17: Premises

The centre was laid out to meet the needs of the service and the number and assessed needs of residents. There was adequate private and communal accommodation. Rooms were of a suitable size and layout and included suitable storage arrangements. Some maintenance was required including repainting in many areas and a review of the ceiling in the utility room. Some areas including the grouting showers and seals around some windows required additional cleaning.

Judgment: Substantially compliant

Regulation 20: Information for residents

The guide prepared for residents of the centre required review to ensure that it reflected the current management team and the staffing levels in place.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Residents' individual risk assessments had not been reviewed in over two years.

Some of the controls outlined in the centre-wide risk register were not in place. Not all hazards had been assessed.

Judgment: Not compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare-associated infections including COVID-19. There were no records available to indicate that staff had recently completed training in infection prevention and control and hand hygiene. The COVID-19 contingency plan required review to ensure that it was up-to-date and reflective of this centre. The centre was observed to be clean. However some damaged surfaces were observed throughout. These included the kitchen counter, bedroom storage units, and some bathroom fittings. It would not be possible to effectively clean these surfaces. First aid supplies were required.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety systems in place in this designated centre included a fire alarm, emergency lighting and fire fighting equipment. Fire drills were taking place regularly. A drill in night time conditions was planned. A self-closing mechanism on the fire door to a high risk area required review to ensure that if required in the event of a fire, it would be effective.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

As there were no residents staying in the centre at the time of the inspection it was not possible to review this regulation in full. Facilities were available to store medicines securely. The provider's own policy and procedures regarding the receipt and return of medications were routinely not implemented in the centre. A medication audit had not been completed since February 2020. The signature bank in place to support the oversight of medication administration in the centre did not include all members of the current staff team.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Comprehensive assessments of the health, personal and social care needs of each resident who stayed in the centre had not been completed on an annual basis. It could not be determined if residents' personal plans reflected their current needs. Personal plans had not been reviewed annually. A multidisciplinary review of residents' personal plans had not taken place that took into account changes in circumstances and new developments.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not 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	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for East County Cork 2 OSV-0003290

Inspection ID: MON-0029771

Date of inspection: 09/01/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: PIC has put a staff training plan in place and will book staff on outstanding mandatory training courses when available and as required. Positive Behavior Support training completed 17/01/2023 Manual Handling Practical Training 17/01/2023. 19/01/2023, 15/02/2023 Food safety training booked for 24/01/2013, 21/02/2023 and 28/02/2023 Documenting and recording of Care for Healthcare Assistants 23/03/2022 Remaining staff member booked for buccal Emergency Training 23/03/2023 PIC will ensure staff have access to Hseland to complete relevant online training for IPC, Hand Hygiene, HIQA Rights PIC will audit training records monthly.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The PIC has updated all current Directory of Residents to ensure all pertinent information is included.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Pic has reviewed and updated all ECC2 protocols for Admission and Discharge documentation (community notes, visit to ECC2, medication, money), weekly resident forums, medication administration protocol, PIC will review all relevant admission and discharge documentation fortnightly and discuss any actions at staff handover meetings. Hospital passports updated and corrected. PIC will organize training and support staff with all record keeping in ECC2 to include Personal Plans, Risks, Rights restriction, NIMS and key worker responsibilities. Personal Care Plan review schedule in place by PIC and key workers	

New Audit Schedule in place	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: New governance structure in place, a centre improvement plan is underway to reflect the HIQA compliance plan, the 6 monthly and annual reviews with progress dates being adhered to. Staff meetings held monthly PIC has scheduled Performance management meetings with staff. PIC has scheduled timetable for reading policies in ECC2 PIC has scheduled staff and safety meetings for 2023.	
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: The PIC and Short Breaks Coordinator are regularly meeting to schedule partial short breaks (limit of staffing resources) for first quarter of 2023 The PIC has begun the process for all Persons Availing of Respite Accommodation to have a Contract of Agreement/care in place.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The SOP is being amended to reflect accurate Floor plan of ECC2 along with any other details that were raised on the day of inspection; Correct telephone contact number, no emergency admissions, no charges, remove social leader information and amendments to emergency procedures.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The Person in charge has submitted retrospective quarterly notification in relation to rights restriction within ECC2. The Person in charge will ensure all future notifications are submitted as per the regulation	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: All painting and repairs needed to the centre have been submitted through our internal maintenance system with a schedule of planned works in place, the bathroom fixtures and fire door are complete. Facility Manager will be requested to carry out a walk though of ECC2 with the PIC and agree works that need to be completed that are outstanding from previous inspections.	
Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents: The Person in Charge has reviewed and amended Residents guide which is available in ECC2. in relation to staff numbers on duty day and night,

Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: There is a system in place in the centre for assessment, management and ongoing review of risk in the risk register. The Person in Charge has reviewed, amended and updated Risk Register to reflect current controls, included adding staffing levels risk to Register. Review, amendment and update of all individual risk assessments is underway as per planned schedule developed.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: The COVID-19 contingency plan reviewed and amended. All staff have completed Infection Prevention and Control and hand hygiene on Hseland. PIC has organized practical hand hygiene assessments for staff with assessor from another designated centre. These assessments will be completed by 28/02/2023 PEMAC requests sent to maintenance department to repair damaged surfaces within ECC2. New handrail in shower room. First aid box stocked.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: EEC2 has the correct policy and procedures in place to protect against the risk of fire, what to do in the event of a fire or a false alarm and to maintain all fire equipment. All self- closing fire doors checked and working effectively. A night time drill has taken place. All staff are compliant in fire training PIC will review and update all Individual Personal Emergency Evacuation Plans to include if support is required at assembly point.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The Person in charge will ensure all staff adhere to Cope Foundation Medication policy and current protocols in ECC2 to ensure records are completed accurately. Staff signature bank updated and in situ. Medication audit completed 02/02/2023	

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A schedule is in place for the reviewing and updating of all personal plans.

This review will be in conjunction with the individuals, staff from day services and their families.

PIC will liaise with relevant days services to link with their schedule PCPS of individuals availing of short breaks in ECC2

Personal plans will be audited in relation to effectiveness 3 monthly.

Key Worker system will be implemented

Multidisciplinary meeting schedule in place 16/02/2023 and

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/04/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/08/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/08/2023
Regulation 19(3)	The directory shall include the	Substantially Compliant	Yellow	12/01/2023

	information specified in paragraph (3) of Schedule 3.			
Regulation 20(2)(a)	The guide prepared under paragraph (1) shall include a summary of the services and facilities provided.	Substantially Compliant	Yellow	10/01/2023
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	30/06/2023
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	30/06/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/06/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Not Compliant	Orange	13/12/2022

	designated centre to ensure that the service provided is 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	30/06/2023
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	10/01/2023
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support,	Not Compliant	Orange	30/04/2023

	develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	10/01/2023
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 terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	31/03/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of	Not Compliant	Orange	31/03/2023

	risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	31/03/2023
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/01/2023
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is	Substantially Compliant	Yellow	12/01/2023

	administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	28/02/2023
Regulation 31(1)(a)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: the unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre.	Not Compliant	Orange	15/01/2023
Regulation 31(4)	Where no incidents which require to be notified under (1), (2) or (3) have taken place, the registered provider shall notify the chief inspector of this fact on a six monthly basis.	Not Compliant	Orange	10/01/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health,	Not Compliant	Orange	31/12/2023

	personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	31/05/2023
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	31/12/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Not Compliant	Orange	31/12/2023

	needs or circumstances, which review shall take into account changes in circumstances and new developments.			