Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 14
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	11 October 2022
Centre ID:	OSV-0003293
Fieldwork ID:	MON-0031366

About the designated centre

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

Cork City North 14 is part of a purpose-built housing development located in an urban setting. It is located within walking distance of local shops and facilities. The service provides full-time residential support to eleven female adults with a diagnosis of intellectual disability or autism. The centre is comprised of three floors which are interconnected by stairs. Each resident has their own en-suite bedroom located throughout the designated centre on all floors. Each floor has a kitchen, dining area and living room. Laundry facilities, visiting rooms and staff office are also available. Cork City North 14 can accommodate individuals with a range of medical and physical needs. Residents are supported by nursing and care staff during the day and there are two staff on duty by night in the centre. The multi-disciplinary team are also available to further support residents when required. Residents are supported to access other services such as GP and chiropody as required.

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
Tuesday 11 October 2022	09:40hrs to 18:05hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

Cork City North 14 is part of a purpose-built housing development located on the outskirts of Cork City. The centre was located over three floors which were connected by stairs. Each resident had their own bedroom with an ensuite bathroom. On the ground floor there was a laundry area used by all residents, a staff office, toilet, and two residents' bedrooms. On the first floor there were five residents' bedrooms and a staff changing area. On the second floor there were four residents' bedrooms, a visitors' room which also had an ensuite bathroom, and a storage room. Each floor also had a living room and a kitchen and dining room. The designated centre was registered to accommodate 11 residents and provided a full-time residential service only.

This was an unannounced inspection. On arrival, the inspector met very briefly with a resident and staff member as they were leaving the centre to attend a day service. The inspector was greeted by another member of staff and shown around the premises. The person in charge was on leave on the day of this inspection, as was the other member of the management team who reported to them. The recently proposed person participating in management of the centre came to the centre to meet with the inspector, and also attended the feedback meeting with another senior manager, the former person participating in management, the following day.

The provider was issued with two urgent actions following the feedback meeting. Based on the findings of this inspection there were significant concerns regarding the governance and management arrangements, including management presence, in the designated centre. This also impacted on the management of complaints. Findings also indicated that the centre was not sufficiently resourced. The findings that prompted the issuing of urgent actions regarding Regulation 23: Governance and Management and Regulation 34: Complaints are outlined in the next section of this report.

The inspector was introduced to residents as they walked around the centre. Some residents were not in the centre when the inspector arrived but over the course of the day, the inspector spent time with all 11 residents. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

When walking throughout the designated centre it was identified that the floor plans submitted at the time of the most recent application to register the centre were not accurate. The provider was therefore asked to submit accurate floor plans, a floor plan declaration, and an application to vary the registration conditions of the centre.

The centre was decorated in a homely manner. Photographs, posters and artworks were on display. The living room areas had comfortable furniture, soft furnishings and televisions. It was noted that the kitchen and dining room on the ground floor

of the centre was larger than the others and had more cooking equipment and food stores. Those on the other floors did not have an oven or stovetop but did have a kettle, toaster, microwave and small refrigerator. There was exercise equipment available in the living room on one floor. One resident told the inspector that they used it sometimes in the mornings. Each resident had their own bedroom and some residents invited the inspector to see them. Bedrooms had been decorated in line with residents' tastes and preferences and were reflective of their interests. Residents who required it had specific equipment to aid their mobility installed. Some had chosen to have a television. Residents told the inspector that they were happy with their bedrooms and some spoke of plans they had to improve them. One resident spoke with the inspector about their wish to change their bedroom around and get a new storage unit. Another wished to update the photos on their wall. The centre was observed to be clean in general but there were some exceptions to this, most noticeably the extractor fans and vents throughout the building. The inspector was informed that an external cleaning company came to the centre every weekday but had not arrived as planned that day. At the time of the last inspection, completed on behalf of the chief inspector in April 2021, it was identified that re-painting was required throughout the centre. That was also a finding of this inspection. A number of areas requiring maintenance were identified by the inspector and others were highlighted to them by residents. These will be outlined in more detail in the 'Quality and safety' section of this report.

Many residents were happy to speak with the inspector, while some chose not to. This choice was respected. Residents told the inspector about what they had done, or planned to do, that day. Residents had a broad range of interests and spoke about their jobs, the sports teams they were part of, fashion, and their favourite music. Some residents had been to concerts and the cinema in recent weeks. Residents enjoyed watching television and were seen doing this. They also spoke about their favourite programmes. Residents participated in everyday activities on the day of the inspection such as visiting the dentist and pharmacy, making a cup of tea, and doing their laundry. Some residents expressed that they liked going for walks but only one resident told the inspector that they would leave the centre on their own, without the support of staff, a relative, or friend. Family members were very important to some residents and many spoke with the inspector about recent outings or planned visits to meet with relatives. Some residents regularly stayed overnight in their family homes. One resident's sibling was due to visit from the United States in the coming weeks and they were looking forward to seeing them again.

Some of the residents spoken with were knowledgeable about the day to day running of the centre. They told the inspector about fire drills they participated in, staffing arrangements, the cleaners who came to the centre, and the keyworker system implemented in the centre. Two residents spoke about goals that they were being supported to achieve. Some residents highlighted things about the centre that they would like to change. One resident spoke about how busy the staff can be when there are only two working in the centre and how difficult it must be for them. When asked if this had any impact on them, the resident replied that it meant that they didn't get out as much as they would like. Another resident told the inspector that they wished to live somewhere else, with people closer in age to them. They

had lived in the centre for many years and expressed that it used to be quieter. When this was raised with members of the staff team, one advised that this resident had discussed this with them for the first time the previous day. In addition to living with people closer to their own age, they had said they would like to go to respite to get a break from the centre. Staff advised that they had made note of what the resident had told them and emailed the person in charge regarding this.

Residents were quick to tell the inspector which floor of the centre their bedroom was on. Many, but not all, chose to spend the majority of their time when in the centre on that floor. One resident told the inspector that it was a rule of the centre that you could only spend time in the living room on your floor and would be asked to move if in one of the other ones. They appeared happy with this arrangement. Another resident also told the inspector about this perceived requirement and advised that they would usually only go to the ground floor to bake, or to take their medicines. On the day of inspection, two residents who did not sleep on the ground floor spent a lot of time there. These residents appeared to require or request more staff support and interaction.

Firm friendships had been developed between some residents, with one resident telling the inspector that they would be lost without one of their friends. Some residents chose to go to certain activities together and two friends spoke excitedly about an upcoming birthday celebration that they were looking forward to. While some reported that all who lived in the centre got on well together, three residents spoke with the inspector about the challenges they and others experienced in living with one resident. When speaking about this situation, residents spoke about being upset by this peer, feeling that they were always 'at them', and that while others were aware of the situation nothing was done about it. The noise levels in the centre, as a result of this living arrangement, were also discussed. When asked about the compatibility of all 11 residents to live together, staff who spoke with the inspector acknowledged that while there were strong friendships, there were also those who did not get on well together. Again, the presentation of one particular resident and the impact of this on others was highlighted. The suitability of this centre for this resident, given their assessed needs, was also questioned. This will be discussed further later in this report.

In the April 2021 inspection, the provider was found to be not compliant with the regulation regarding staffing. Staffing was highlighted to the inspector by staff and residents and remained a significant issue. This will be discussed in more detail in the next section of this report. On the day of the inspection there were four staff working in the centre. One of these was funded separately to provide one-to-one staffing to one resident only and spent part of the day with them at their day service. Another staff member was employed as an activities coordinator and worked in the centre from Monday to Friday. At night, two staff completed waking shifts from 8PM to 8AM. Residents spoke very positively about staff with the inspector. All interactions observed by the inspector were warm and supportive. Residents and staff had clearly developed good relationships and many of their interactions were light-hearted and friendly. Staff displayed a very good knowledge of each resident, their interaction styles, and support needs. One staff member told the inspector that they had worked with this group for over 10 years and the

benefits and impact of that long working relationship were evident. Over the course of the day that the inspector spent in the centre, residents sought support, reassurance, help, comfort and company from staff. These were provided in a respectful and unhurried manner.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. The inspector looked to review the consultation with residents and their representatives conducted as part of the centre's annual review, however this was not available.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents 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. Staff rosters and training records were reviewed which indicated ongoing non-compliances with the regulations. The centre's risk register was reviewed and was found to include a number of high rated risks. The provider's response to these risks was not clearly documented. The inspector also looked at a sample of elements of residents' individual files. Areas for improvement were identified and will be outlined in more detail in the 'Quality and Safety' section of this report.

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

The provider was required to significantly improve the governance and management practices implemented in the centre to ensure effective oversight and sustainable and safe delivery of care and support to residents living in this centre.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. Care and nursing staff reported to two managers who worked alternating shifts, and they reported to the person in charge. The person in charge reported to a regional manager who had been proposed as the person participating in management of the centre. On the day of this inspection, due to leave, the only member of the management staff on duty was the regional manager. They had been appointed to the role in August 2022.

The person in charge also fulfilled this role for two other designated centres. They and the two managers who reported to them were based in one of these centres. When asked if any of the managers had an assigned day or time based in this centre, staff advised that a member of the management team supervised a visit for

one resident on a monthly basis and at times, due to staffing shortages, would visit the centre to administer medicines. The inspector reviewed staff meeting minutes available in the centre. There was a record of one staff meeting held in February 2022. This meeting had been arranged the person in charge and was a joint meeting regarding this designated centre and the one they were based in. On review of the attendees, it was identified that none of the current staff team of this centre had attended that meeting. Separately, it was documented that members of the staff team in this centre had convened their own meetings monthly. To date in 2022, no member of the management team had attended any of these meetings. Staff spoken with on the day of inspection advised that they had not attended any staff meetings where a member of the management team was present in recent months. While in the centre, the inspector also reviewed a document which had been put in place to document staff contact with members of the management team. Since 01 July 2022 there were 11 documented entries, six of which related to the provider's night supervisor. It was noted that the person in charge had documented a reduction in the whole-time equivalent hours that they allocated to this centre from 0.4 to 0.3 in November 2021. In June 2022, the provider had assigned another designated centre to the person in charge, thereby increasing their remit and further reducing their capacity to fulfil their responsibilities in relation to this centre. In the course of this inspection there was very limited evidence to support management's physical presence, supervision and oversight in the centre.

An annual review of the quality and safety of care and support in the centre was completed in December 2021. There was no evidence of consultation with residents or their representatives in this review, as is required by the regulations. This has been a repeated finding in centres operated by this provider. In this review, completed 10 months prior to this inspection, representatives of the provider had assessed that the centre was not compliant with eight regulations. These included those relating to governance and management, complaints, staffing, protection, and residents' rights. These poor outcomes were consistent with the inspector's findings during this inspection. There was no action plan regarding this review available in the centre. This was sent to the inspector following the inspection. On review of this action plan, it was identified that a number of actions were not completed or reviewed within the timeframes specified. It was also noted that no actions were documented in response to some areas assessed as requiring significant improvement. The action plan repeatedly referenced the staffing shortages in this and the other centres where the person in charge worked. It also stated that the centre's management team did not 'have daily operational governance' in the centre. Some actions were to be implemented when staffing levels in this and other centres had improved. As staffing remained an issue, these actions were not completed.

The inspector reviewed the staffing arrangements in the centre and reviewed the actual rosters for the month of September 2022. There was no planned roster in place. When asked, staff spoken with were not clear on the full, planned staff complement to work in the centre on any given day. This could not be determined from documents available in the centre. At the time of the last inspection completed on behalf of the chief inspector in April 2021, it was found that a Monday to Thursday shift from 5PM to 10PM, to provide one-to-one support to one resident

was routinely not filled. This was also a finding of this inspection. In addition there were a number of days in the month of September where only two staff worked in the centre. As one resident was assigned, and separately funded, to have one-to-one staff, this meant that only one staff was assigned to support the other 10 residents. It was also identified that for approximately half of the time, this resident did not receive their allocated one-to-one staff support. The statement of purpose also referenced an activities coordinator. It was noted that this role was not staffed in September. The inspector met with this staff member who advised that for a number of weeks that they had been filling vacant shifts and had only returned to their activities-focused role and hours that week. It was clear that the provider had failed to ensure that the centre had sufficient management or staffing resources to ensure the effective delivery of care and support.

The provider had completed twice-per-year unannounced visits to review the quality and safety of care provided in the centre, as is required by the regulations. A visit had taken place in September 2021 and again in March 2022. In September 2021, it was assessed by the provider that the centre was not compliant with the regulations regarding staffing, governance and management, and protection. Again, there was reference to staffing shortages and the demands placed on the person in charge due to their role in another designated centre. The March 2022 visit report was not available in the centre and was sent to the inspector following the inspection. During this visit, the provider identified that the centre was not compliant with the regulations regarding staffing, residents' rights, residents' contracts and medicines management. The inspector was informed that although this visit was completed seven months prior to this inspection, the action plan had not yet been documented but that there had been some follow up on matters raised. The provider's own audits had identified many areas requiring significant improvement but insufficient action had been taken to address them. Some of these issues, as will be discussed in the next section of this report, had also been escalated to senior management using the risk management procedures. These collective findings resulted in the issuing of an urgent action in relation to governance and management in the designated centre.

The inspector also reviewed the complaints log. It was found that three complaints remained unresolved. When speaking with staff on duty they advised that the most recent complaint, made in July 2022, had been addressed to the satisfaction of the complainant. They also advised that the person in charge had met with the resident who made the complaint to discuss the matter. None of this had been documented, as is required by the regulations. In March 2022, a complaint was made on behalf of a resident who was not able to attend their day service due to staffing shortages. This resident was funded to receive one-to-one support and had a place to attend a day service four days a week. However, following the resignation of one staff member, this resident only accessed these funded supports 50% of the time which meant their attendance at their day service was significantly reduced. Although this matter had been brought to the attention of the person in charge and other senior management, there were no actions documented to address this matter seven months later. In February 2022, a resident had complained that none of the staff on duty could drive and therefore they could not go on an outing. The documented response was that management were aware of this issue and would look at it as

best they could. The complainant was not satisfied with this response and eight months later there had been no measures required for improvement put in place, or escalation in line with the provider's own policies and procedures. These open complaints demonstrated poor oversight and response to complaints in the centre and resulted in the inspector issuing an urgent action.

A review of the centre's training matrix indicated that a number of staff required training in areas identified as mandatory in the regulations. These included fire safety, training in the management of behaviour that is challenging including de-escalation and intervention techniques, and infection prevention and control.

The inspector also reviewed the statement of purpose available in 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. The document was last reviewed in November 2021 and required updates in a number of areas. These included the personnel included in the organisational structure, the change to the person in charge's remit given the addition of another centre, and in the description of rooms in the centre and their uses. It was also identified that the staffing whole-time equivalents outlined were not accurately calculated.

Registration Regulation 5: Application for registration or renewal of registration

The floor plans submitted at the time of the most recent application to renew the registration of the centre were not accurate.

Judgment: Substantially compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The provider had paid the annual fee as outlined in this regulation.

Judgment: Compliant

Regulation 15: Staffing

The number of staff working in the centre was regularly not appropriate to the number and assessed needs of the residents and the statement of purpose.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff did not have access to appropriate training, including refresher training.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents review required review to ensure that all information included was accurate. It was identified that two different admission dates were documented for one resident.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not ensured that the centre was adequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. The management systems in place did not ensure the service provided was safe, appropriate to residents' needs or effectively monitored. The annual review did not provide for consultation with residents or their representatives. Plans had not been put in place to address concerns identified 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.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that the information included was up-to-date and accurate.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all restraints used in the centre had been notified to the chief inspector, as required by this regulation.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had not ensured that all complaints were investigated promptly, that measures required for improvement in response to complaints were put in place, and that accurate records regarding complaints were maintained in the centre. The poster regarding the complaints process on display in the centre required review to reflect recent personnel changes.

Judgment: Not compliant

Quality and safety

The resource shortfalls in the centre had a negative impact on the compliance levels with the regulations regarding quality and safety. While some residents enjoyed living in this centre and led full, busy lives, others were restricted in living the lives of their choosing by the supports available to them. The absence of appropriate governance, management and oversight outlined in the previous section resulted in poor management of risk and insufficient responses to identified behaviour support and safeguarding matters.

Staff advised that many residents chose not to return to day services on a full-time basis following the closures implemented as a result of the COVID-19 pandemic. Staff advised that one resident attended a day service from Monday to Friday. Other residents' attendance at day services ranged from one to four days a week, with most attending for two days or less. Two residents attended a retirement group held in the same building twice a week which they enjoyed. Some residents had jobs, with two speaking with the inspector about their responsibilities working in a kitchen, and in an office. The centre's activities coordinator spoke with the inspector about local activities residents enjoyed. These included going to the gym, Mass, for coffee, bowling, swimming and to the library. The inspector was told that previously residents completed courses in the local arts centre. These had stopped as a result of the pandemic but staff had recently got a copy of the new brochure and were hoping that residents would attend classes there again. Two residents were members of a basketball team and attended training weekly. Others were training to

complete a fun run, while some participated in Special Olympics. Both staff and residents highlighted to the inspector that the ongoing staffing issues in the centre negatively impacted on residents' ability to participate in community-based activities in line with their wishes. The person in charge had also documented, in risk assessments, that the staffing shortages in the centre restricted residents' ability to engage in activities of their choice and to use community amenities.

The inspector was also told that residents enjoyed going to the canteen on the provider's campus for lunch. It was explained that this was often a social activity for residents. On the day of this inspection, food was sent from the canteen to the centre. Staff explained that they had tried to call that morning to book into the canteen but couldn't get through. Asked why they did not prepare meals in the centre, staff responded that breakfasts and evening meals were made there and also all meals at weekends. One resident chose an alternative meal for lunch and this was freshly prepared.

As was identified in the April 2021 inspection, there continued to be one resident living in the centre on a temporary basis since 2016. In their compliance plan, the provider advised the chief inspector that this would be addressed by the end of November 2021. Although an alternative option had been identified for this resident, it had not progressed as planned. At the time of this inspection, there was no plan to support this resident to move to their own home. Each resident had a personal plan in place. As is required by the regulations, each plan was subject to a multidisciplinary review carried out annually. The documentation regarding these reviews was read by the inspector. It was noted that some significant issues relating to residents were not discussed as part of these reviews. For example, the situation whereby one resident was not receiving one-to-one support as planned was not noted.

Residents who required one, had a behaviour support plan in place. However, the majority of those read by the inspector had not been reviewed in the previous 12 months, as is required by the regulations. The information outlined in one plan was not consistent with what staff had reported regarding the seating arrangements when this resident travelled in a car with their peers. When reviewing another plan, developed in 2019, the inspector saw handwritten notes on the plan querying the accuracy of the information outlined. It was therefore assessed that staff did not have access to up-to-date knowledge to respond and to support residents with any behavioural challenges.

The person in charge is required to notify the chief inspector of any occasion where a restrictive procedure is used in the centre. The chief inspector had been informed of the use of a behaviour support plan where a preferred item was taken from a resident for a period of time as a result of them engaging in specific behaviours. The inspector reviewed the protocol in place and found it was unclear when staff were to implement this restriction. The inspector had observed the specified behaviours during the inspection, however this plan was not implemented in response. Staff advised that they found this procedure effective, however had requested a review for clarity on its use. This had been arranged but was postponed due to the absence

if the person in charge.

The resident had previously asked that this protocol be discontinued, which it was for a period of time. There was documentation that the resident had most recently agreed to this approach in May of this year and had requested its review after Christmas 2022. It was also documented that when discussing this arrangement with the resident, they had been told that a consequence of them previously deciding not to agree to this protocol was a panic attack which required hospital treatment. This approach to behaviour support did not seem consistent with a human rights based approach to providing care and support. It was not clear from the documentation available what additional and alternative approaches had been implemented when this procedure was temporarily suspended. According to the document in the centre, this resident's behaviour support needs were not discussed or reviewed as part of the multidisciplinary review of their personal plan.

When in the centre, it was identified that some external doors were locked or only opened a small amount for ventilation purposes. It was also noted that cupboards in a communal area used to store food, decorations, activities, and residents' personal items were routinely locked. As outlined in the opening section, two residents spoke with the inspector about their understanding that they had to stay on their own floor when in the designated centre. These restraints had not been recognised as such and had therefore not been subject to the provider's own policy and procedures.

Due to the matters raised by residents, the inspector reviewed a sample of the safeguarding plans in place in the centre. Of the sample reviewed all had been initially written in either 2018 or 2019. Although it was documented on a separate sheet that a review had been completed at least annually since, no changes had been made to the safeguarding plans as part of these reviews. All plans made reference to one resident having one-to-one staff support. As previously outlined in this report, that support was routinely not provided. This longstanding staffing issue was not reflected in the plans. One resident was regularly referenced in the sample of safeguarding plans that the inspector reviewed, however this was not the resident highlighted by three residents when speaking with the inspector.

As mentioned in the opening section three residents reported challenges experienced by them and others in living with one resident. Individual risk assessments for this resident had been completed. High rated risks included them being verbally aggressive towards others, antagonising their peers, and experiencing heightened anxiety levels. When discussing the documented control measures, staff advised that not all of these were still in place. Neither the provider's response to these escalated risks, nor planned additional controls to mitigate these high-rated risks were documented. Despite these risk assessments and the information shared by residents and staff, there was no reference to these issues in the multi-disciplinary review of this resident or others' personal plans, or in their safeguarding plans.

The inspector also reviewed the centre's risk register. This had been last reviewed in November 2021. The register included a number of high-rated risks. These included rights restrictions on residents, peer-to-peer aggression, environmental disturbance,

work-related stress and challenges to meeting staff training requirements. The majority of these risk assessments made reference to staffing shortages in the centre. Despite their high rating, these risks had not been reviewed in the previous ten months and there was no documented response from the provider on these matters. These risks remained evident in the centre on the day of this inspection.

In conversation with staff regarding risk assessments, it was identified that the majority of residents were checked hourly by night when sleeping in the centre. Staff advised that this was routine practice and was not always in place due to a medical or other assessed need. One resident had objected to this and as a result was now checked only twice a night. Again, it was not clear or documented why this monitoring was required.

As referenced in the opening section of this report the general upkeep of the designated centre required improvement. Painting was needed throughout the building. Damaged surfaces were noted on units in the staff office & under sinks in the laundry, on the laundry counter, and on the storage units in a number of residents' bedrooms. One resident highlighted to the inspector that the tiled backsplash in their ensuite was damaged. In another ensuite bathroom, it was noted that the flooring was damaged. A number of chairs throughout the centre also required either repair or replacement due to damaged, torn, or peeling upholstery. This included the couch available in the visitors' room. The wall and flooring in the ensuite bathroom adjoining the visitors' room was also damaged. A windowsill in one of the living room areas was also noticeably damaged and required repair. Management advised that requests had been made to the provider's own maintenance department to address some of these matters and works were scheduled.

Regulation 13: General welfare and development

Residents living in the centre had access to recreational and educational activities in line with their interests. Residents were supported to develop and maintain personal relationships that were important to them. Residents were familiar with the local area and were involved in community-based activities. However, insufficient resources in the centre negatively impacted on residents' opportunities to participate in activities outside the centre, including attending day services, as much as they wished.

Judgment: Substantially compliant

Regulation 17: Premises

The centre was generally clean and was decorated in a homely manner.

Maintenance works were required to ensure it and its furnishings were kept in a good state of repair.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The system in place did not assess, manage or review risk on an going basis. A number of high-rated risks were not regularly reviewed and did not outline additional measures to reduce or mitigate against these identified risks. Some of the documented control measures to mitigate risks were no longer in place.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

One resident lived in the centre on a temporary basis since 2016. There was no plan in place for this resident to move to a permanent living arrangement. Therefore, arrangements were not in place to meet the needs of this resident, as assessed by the provider.Not all plans had been reviewed in the previous 12 months, as is required by the regulations. Multidisciplinary reviews of residents' personal plans did not assess the effectiveness of residents' plans or take into account changes in circumstances. It was also noted that the names of those responsible for pursuing objectives in the plan were not always recorded.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Staff did not have up to date knowledge to respond to, and to support residents with, behavioural challenges. Not all restrictive procedures used in the centre had been recognised, and were therefore not subject to the provider's policy. It was not documented that all alternative measures were considered prior to resuming the use of a restrictive procedure for one resident. The finding regarding staff training is addressed in Regulation 16.

Judgment: Not compliant

Regulation 8: Protection

The registered provider did not have the measures in place, as documented in residents' safeguarding plans, to protect residents from all forms of abuse. Although risk assessed, the impact of one resident on others had not been considered from a safeguarding perspective.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Regular residents' meetings were held in the centre. The majority of residents were routinely checked hourly by night, without any documented rationale for this intervention which infringed on residents' privacy and dignity in relation to their personal living space.

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	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 14 OSV-0003293

Inspection ID: MON-0031366

Date of inspection: 11/10/2022

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**
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: The provider will ensure the floor plans submitted for application to renew the registration of the centre will be updated and accurate as set out currently in CCN14. The Facilities manager will furnish provider with same.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider will ensure the number of staff working in the centre is appropriate to the number and assessed needs of the residents in the statement of purpose. PIC, PIIM and HR are proactively reviewing recruitment pathways to comply with this regulation.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and	

staff development:
The registered provider has identified a team to roll out dates for mandatory staff training.
The PIC will arrange for all staff to be facilitated appropiate opportunities to attend the training including refresher training dates as they are made available.

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
The registered provider and PIC will ensure that the directory of residents information is accurate.
Error regarding two different admission dates documented for one resident amended.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
From Monday 17th October one CNM1 will be onsite in CCN14 5 days per week to ensure effective daily governance in the Centre. The CNM1 will be supported by the PIC or deputy daily via telephone and the PIC or deputy will spend up to 1.5 days per week in the centre.
• Management team will continue to liaise with HR to fill 0.5 WTE vacancy in the centre and relief or agency staff will be redeployed where possible to the centre.
• Lines of reporting protocol will be developed so that staff have access to a manager at all times either onsite or via telephone.
• A schedule of staff meetings will be put in place with first staff meeting to be held with staff and management team including regional manager on Friday 21st October.
• A schedule of performance management reviews will be devised with aim to commence formal supervision of staff in the next two weeks. Schedule will be in place by Friday 21st October.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The registered provider will ensure the statement of purpose information included is up-to-date and accurate about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. • Personnel in place updated in the organisational structure since last review – new PPIM • The change to the person in charge's remit reduced with removal of another centre he was PIC. • The description of rooms in the centre and their uses. Staffing whole-time equivalents are accurately calculated.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The registered provider will ensure that any measures used in the Centre that are deemed necessary as a restraint in the centre will always be notified to the chief inspector, as required by this regulation. • The PIC will review restrcitive measures used in the Centre with regard to locked press, to explore alternatives. • Residents have freedom of movement within their home to access all areas of the Centre, however measures were taken to avoid congregation of residents during Covid on the ground floor. Pic and staff will review communication around this. • The PIC and staff will continue to ensure safeguarding measures identified in the Centre remain in place to support supervision of safety for all residents as well as protected meal times. PIC will review and engage with PBST with regard to notified existing restrictive measure that was developed by PBST.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The registered provider will ensure that all open complaints will be investigated by management on Friday 14th October. • Complaints will be responded to appropriately in adherence with organizational complaints policy and regulation 34 • All reasonable measures will be taken to resolve outstanding complaints and actions	

will be documented and reviewed within an acceptable timeframe • The PIC has identified a Complaints officer locally who will escalate any complaints to PIC and maintain records of all complaints logged in Cork City North 14. • The PIC will ensure all Investigations, actions taken, outcomes and resident satisfaction with outcome of all complaints will be documented.

Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: The registered provider will ensure that there is sufficient resources in the centre to provide all residents' opportunities to participate in activities outside the centre, including attending day services, as much as they wished. • The PIC and PPIM is liasoning with HR regarding reviewing recruitment to ensure the fulfilling of all staff gaps identified in the Centre. PIC and PPIM will further explore community based activites that residents may wish to participate or engage in if they so wish.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The registered provider will ensure the centre maintenance works are addressed in a timely manner and its furnishings are kept in a good state of repair. • PPIM/PIC will address any outstanding maintenance actions with the Facilities manager. • PPIM/PIC will have a walk through the Centre to identify works required with Facilities manager on-site. All furnishings already requested will be addressed for repair or replacement via PEMAC maintenace system – if not already completed.	
Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider will ensure that all risk management procedures are reviewed and updated on an going basis.
• The PIC will review and update all high-rated site specific risks and outline any additional measures to reduce or mitigate against these identified risks.
The PIC will ensure all control measures to mitigate risks are in place and implemented as documented.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The registered provider will review the outstanding action plan regarding one resident living in the centre on a temporary basis.
The PPIM and PIC will review and idendtify the support this resident requires to move to a permanent living arrangement to meet the needs of this resident, as assessed by the provider.
• The PIC will ensure all personal plans continue to be reviewed within timeframes as required by the regulations.

• The PIC will review all Multidisciplinary needs of residents within their personal plans and evauluate the effectiveness of residents' plans to include any changes in circumstances, or needs if requiring attention.

• The PIC will ensure those responsible for pursuing objectives in residents personal plans are recorded. The PIC has advised staff and developed a step by step process for recording any actions taken by staff including dates completed in any pursuit of objectives / goals in line with residents will and preference.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The registered provider will ensure that all staff have up to date training and knowledge to respond to, and to support residents with, behavioural challenges.
• The PIC will continue to schedule staff for both MAPA training and PBS training so that

all staff will have the necessary training required.
• The PIC will meet with staff to discuss and review the measures taken locally as recognised in this report as restrictive procedures used in the centre.
• The PIC will continue to submit a rights restriction notifiable as required in line with the provider's policy.
The PIC will review with the PBST the use of a restrictive procedure noted in the report for one resident.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The registered provider will ensure that measures are in place, and documented in residents' safeguarding plans, to protect residents from all forms of abuse.
• The PIC has reviewed and risk assessed safeguarding needs within the centre.
• PIC, PBST and Safeguarding Designated officer to review a residents behaviour and potential negative impact on other residents' from a safeguarding perspective.
The PPIM and HR will continue to review staffing gaps to ensure staffing levels within the Centre.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The registered provider will ensure to
• The PIC will review the current practice of checking on residents at night, to enable the development of documented rationale for each residental for this intervention if necessary.

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	31/12/2022
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.	Substantially Compliant	Yellow	28/02/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and	Not Compliant	Orange	28/02/2023

	skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/12/2022
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	28/02/2023
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	28/02/2023
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	30/11/2022

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	Red	17/10/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Red	17/10/2022
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.	Not Compliant	Orange	31/01/2023
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	Not Compliant	Orange	28/02/2023

	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.			
Regulation 23(2)(b)	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 maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Substantially Compliant	Yellow	28/02/2023
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	Not Compliant	Red	17/10/2022

	residents.			
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	31/12/2022
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	30/11/2022
Regulation 31(3)(a)	The person in charge shall 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.	Not Compliant	Orange	31/01/2023
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for	Substantially Compliant	Yellow	30/11/2022

	residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Red	17/10/2022
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	30/11/2022
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Red	17/10/2022
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on	Not Compliant	Red	17/10/2022

	foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	28/02/2023
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	31/01/2023
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 needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	31/01/2023
Regulation	The	Substantially	Yellow	30/03/2023

05(7)(c)	recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Compliant		
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	28/02/2023
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.	Not Compliant	Orange	31/01/2023
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative	Substantially Compliant	Yellow	31/12/2022

	measures are considered before a restrictive procedure is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	28/02/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	31/12/2022