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

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| Name of designated centre: | East County Cork 1 |
| Name of provider: | COPE Foundation |
| Address of centre: | Cork |
| Type of inspection: | Announced |
| Date of inspection: | 10 June 2022 |
| Centre ID: | OSV-0003305 |
| Fieldwork ID: | MON-0027736 |

## About the designated centre

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

The designated centre provides full-time and shared residential care and support for up to 18 adult males and females with intellectual disability and / or autism. The centre is located within a large town. The centre is a single storey building, with residents having access to communal facilities such as a large sitting room, dining room, relaxation area and kitchen. There are 10 single occupancy and four shared (double occupancy) bedrooms in the centre. Some bedrooms have access to en-suite bathroom facilities. The centre further provides residents with bathroom and laundry facilities, visitors / quiet room and garden areas that were well maintained. In addition, the centre has a staff office and staff toilets. Residents are supported by both nursing and care staff at the centre. At night-time, residents are supported by two waking staff on duty. A day service is adjacent to the designated centre.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 16 |

## 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 |
|---|---|---|---|
| Friday 10 June 2022 | 09:30hrs to 19:00hrs | Caitriona Twomey | Lead |

## What residents told us and what inspectors observed

The centre was a single-storey, purpose-built building on the outskirts of a large town in County Cork registered to accommodate 18 adults. A day service operated by the provider was located in the same building, adjacent to the designated centre. Management advised that all residents participated in some activities in the onsite day service. There were 16 residents in the centre of the day of the inspection. One resident had not returned to the centre since the beginning of the COVID-19 pandemic in March 2020. Another resident, although staying regularly, now spent less days per week in the centre. The inspector had the opportunity to spend time with 15 residents.

This was an announced inspection. As the person in charge was not available, the person participating in management and another member of the centre's management team facilitated the inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control (IPC) procedures were in place. The inspector and all staff adhered to these throughout the inspection.

Management advised that six residents lived in the centre on a full-time basis. This opportunity was available to the other residents however most chose to spend some time every week or every second week staying with family members. Prior to the COVID-19 pandemic the centre was open from Monday to Friday only. This change to the service provided was welcomed by residents, several of whom had previously moved to other designated centres for the weekend. This had been especially challenging for some residents. A respite service was no longer provided in the designated centre. This stopped at the outset of the COVID-19 pandemic in March 2020.

In the report written following the last HIQA (Health Information and Quality Authority) inspection of the centre in May 2021, there was reference to a proposal for four residents to live together in a house in the local community. Management advised that the provider was unable to secure the necessary resources and funding to progress this plan. As will be outlined in the 'Quality and safety' section of this report, this was still the wish of at least one resident.

There were 10 single occupancy bedrooms in the centre and four double occupancy / shared bedrooms. The practice of sharing bedrooms had stopped during the COVID-19 pandemic, however had since recommenced to allow the centre to operate at full capacity. There were posters, signed by the relevant residents, on display in each shared bedroom to demonstrate their agreement to this arrangement. Two single occupancy bedrooms had an ensuite bathroom. Six bedrooms had shared access to an ensuite bathroom with one other bedroom. There were also two larger communal bathrooms. Other facilities available included a commercial kitchen, two sitting rooms, a living and dining room, and a laundry room. Residents had access to a garden area which included a patio and sports

surface.

A chef worked part-time in the kitchen until 2PM from Monday to Friday. At the weekends staff cooked the main meals. At the time of this inspection the chef was on leave. As a result residents' main meals were being delivered from another commercial kitchen located on the campus operated by the provider in Cork City. Staff advised that an option of at least two meals was available to residents. The practice of set meal times was in place with staff explaining that there were two sittings for the main meal each day. Residents who wished to have their meals at a later time were facilitated to do so. Residents who mentioned it, spoke very positively about the food provided in the centre, with one highlighting the soup and another the cakes baked by the chef. One resident had specialised dietary needs. All staff who spoke with the inspector were very aware of these and demonstrated a very good understanding of the resident's needs.

The kitchen was accessed via a door fitted with a keypad. The inspector was advised that the keypad was used when the kitchen was not supervised by staff. Management advised that any resident who wished to was supported by staff to go into the kitchen area. Some residents enjoyed baking and staff spoke with the inspector about supporting them with this activity. As it was a commercial kitchen most food was kept in store rooms off the kitchen. Therefore although residents had access to the kitchen area, food and drinks as requested, these were not as freely accessible to them as they would be in a more domestic and homely setting. Staff had provided the inspector with a trolley with a variety of drinks and snacks. A number of residents approached the trolley with curiosity and asked the inspector if they could have something to eat or drink. They appeared to enjoy this opportunity to see what was available and choose a snack, as would be typical for most people in their homes.

The centre was observed to be clean, bright and decorated in a homely manner. Each bedroom reflected the interests and preferences of the resident or residents staying in them. Some residents had chosen to display photographs, other rooms were furnished with dressing tables and televisions. Residents who shared a bedroom had the option to use a privacy screen. Management spoke with the inspector about recent painting that had been completed following a recommendation for a resident who was experiencing some periods of confusion. A path to, and a frame around, their bedroom door had been painted in one of their favourite colours. This was a proactive measure to support this resident to continue to feel safe and secure in the centre.

When walking around the centre, it was noted that alarms were fitted on a number of external doors and would sound when they were opened. These restrictive practices had not been notified to the chief inspector, as is required by the regulations. It was also noted that there were some holes in some fire doors were fittings had been moved or screws used to attach items. These required review by a competent person to ensure that they would still serve as effective containment measures, if required in the event of the fire. Some areas requiring maintenance were also identified. These will be outlined in the 'Quality and safety' section of this

report.

All interactions observed between staff and residents were warm, respectful and unhurried. Staff appeared to know residents, their support needs, communication preferences and interests well. Staff were positive when speaking about both their roles and the residents with the inspector.

While the inspector was in the centre residents were observed eating meals, watching television, preparing to go to their family homes for the weekend, knitting, having their nails painted, and going to and from the day service. Some residents were very sociable and had developed strong friendships with each other. One resident joined the inspector in one of the sitting rooms and had a cup of coffee with them. While there they spoke about what they liked to do and some of the people they lived with. Others expressed an interest in what the inspector was doing and called back to see them throughout the day. Other residents spoke about their friends, what they liked to do together and their positive experiences of living in the centre. There was a large television in the living room area and the programme on television was a topic of conversation for many. Conversations were light-hearted in nature and laughter was regularly heard. Some residents chose not to engage with the inspector and this was respected.

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. The centre's risk register was reviewed and while comprehensive, further revision was necessary to ensure that the risk assessments were accurate and reflective of the centre. The inspector also looked at a sample of residents' individual files. These included residents' personal development plans, healthcare and other support plans. Areas for improvement were identified and will be outlined in more detail in the remainder of this report.

As this was an announced inspection, resident questionnaires were sent to the provider in advance. Eight questionnaires were completed by residents or their relatives. Overall, the feedback received was very positive, with many respondents stating there was nothing they would change about the service provided. Residents expressed that they were happy and liked living in the centre. Residents were positive about their bedrooms, the staff team and the garden area. Residents reported enjoying a number of activities including shopping, baking, and going to restaurants. It was reported that residents would like to take part in golf, going to the cinema and going out for dinner more often. Opportunities for community based activities will be discussed more in the 'Quality and safety' and section of this report.

The provider had circulated family satisfaction questionnaires. The inspector reviewed 13 of these. The feedback received was exceptionally positive. Relatives described their family members as being very happy while in the centre, with one describing how their face lit up when returning after time spent elsewhere. Staff were described as kind, approachable, enthusiastic, compassionate and supportive.

Respondents also reported that they were encouraged to be involved and that their relatives were encouraged to be independent.

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

Overall, there was evidence of good management systems in place to ensure that the service provided was safe and residents enjoyed living in centre. Management practices ensured that all audits and reviews as required by the regulations were being conducted. However, these audits and the development of action plans to address identified non-compliances required improvement. Clarity was also required regarding the staffing levels to be provided in the centre. Residents' personal plans and written contracts with the provider also required increased oversight.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. All staff reported to a nurse practitioner, who reported to the person in charge. They reported to the person participating in management who reported to the chief operations officer, who reported to the chief executive, who reported to the board. The person participating in management reported that they had regular formal and informal contact with the person in charge.

The person in charge was appointed in May 2021. They had fulfilled this role in another centre previously and prior to that had worked in this centre in a management role. Due to their previous experience it was reported that they knew the residents well and had developed good relationships with the residents and their relatives. The person in charge and another member of the management team were based full-time in the designated centre. When reviewing the management arrangements, it was noted that neither member of the management team worked in the centre in the evenings, at night or at weekends. The person participating in management advised that the provider had a system in place where there was always a senior manager available to staff by telephone.

Staff meetings were held frequently in the centre. Management advised there was no meeting schedule. Records indicated that a range of topics were discussed regarding the day-to-day support and services provided to residents. Topics included fire safety, safeguarding, access to the day service, infection prevention and control (IPC), residents' personal development goals and visitors to the centre. There was evidence that a number of audits were completed by the person in charge in the

centre. These included audits regarding IPC practices, fire safety, medical equipment, and medication management.

The provider had completed an annual review and unannounced visits every six months to review the quality and safety of care provided in the centre, as required by the regulations. These required improvement. It was noted that on some occasions although areas requiring improvement were identified in monitoring reports, these were not always reflected in the judgments given. For example, in the September 2021 annual review it was identified that one contract of care did not have a financial assessment. Despite this, the regulation regarding admissions and contracts for the provision of services was assessed as compliant. A number of shortcomings were also identified in relation to the risk management procedures in the centre. Again this was assessed as compliant. As the regulations were assessed as compliant, no actions were developed to address these matters. It was also noted that actions generated were not always consistent with the findings of the audit. For example, when reviewing the regulation regarding individualised assessment and personal plans, it was identified that person-centred planning goals were limited and lacked fulfilment, that review timetables were not provided, and that content pages would enhance the plans. The only action documented to address these findings was to put a contents page and dividers in place, therefore addressing only part of the findings. The inspector found that there was evidence that any actions documented had been progressed or completed by the person in charge. It was also noted that although there was evidence of consultation with representatives and family members, there was no evidence of consultation with the residents as part of the annual review. This is required by the regulations.

The planned staffing levels were not clearly documented in the centre. This required clarification. Two staff worked overnight in the centre, remaining awake. One staff member worked from 5 PM to 10 PM from Monday to Thursday. Staff informed the inspector that it was their understanding that there should be four care assistants working from 8:00 AM to 8:00 PM from Monday to Friday. This was consistent with the information outlined in the residents' guide. According to the person participating in management, three care assistants should be rostered to work those hours. The inspector reviewed the actual staff roster for one week selected at random. At no time were four care assistants working in the centre during the day. On two days that week there were only two, therefore also below the staffing levels suggested by management. In addition the 5 PM to 10 PM shift had not been filled one day that week. The provider had therefore not ensured that the number of staff provided was appropriate. Three new staff had started working in the centre the week prior to this inspection. There continued to be one vacancy but management advised that a person had been identified to join the team.

There was evidence of good oversight of staff training in the centre. The training matrix was well maintained and reviewed monthly. Gaps were identified in fire safety and the management of behaviour that is challenging including de-escalation techniques. Some staff were booked to attend outstanding training. However this was not always the case. Management advised that there was a backlog to access fire safety training across the organisation due to the restrictions imposed on in-person training during the COVID-19 pandemic. As an interim measure, training had

been provided to four staff on the fire safety policies and procedures in this centre. Management advised that not all staff would receive medication management training. It was explained that when nursing staff were on duty only they administered medications. However these staff did not work in the centre overnight or at the weekends. Training records indicated that 11 staff had the required up-to-date training. Management advised that this was sufficient to meet the needs of the centre.

As was identified in the last two HIQA inspections of this centre signed service agreements did not meet all of the requirements of the regulations. The services provided were also not always clear. For example it was not referenced in some residents' signed agreements that they shared a bedroom or how many days they could stay in the centre.

The inspector reviewed the centre's statement of purpose. 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. This document met the majority of the requirements of the regulations. Some revision was required to this document to ensure that the size of all rooms in this document matched those on the floor plans and to ensure the information outlined was updated to reflect recent improvements in the centre, for example wireless internet access was now available to residents.

The inspector reviewed the centre's complaints log. Any complaints that had been made had been addressed in a timely manner and to the satisfaction of the complainant.

## Registration Regulation 5: Application for registration or renewal of registration

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

Judgment: Compliant

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

The registered had paid the annual fee outlined in this regulation.

Judgment: Compliant

## Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and had the skills, qualifications and experience necessary to manage the designated centre.

Judgment: Compliant

## Regulation 15: Staffing

There was no planned staff rota outlining the required staffing levels in the centre. The numbers outlined in the residents' guide and expressed by staff members differed from those relayed by management. From the sample week reviewed, the registered provider had not ensured that the number of staff was appropriate on three out of seven days.

Judgment: Not compliant

## Regulation 16: Training and staff development

Some of the staff team required training in fire safety and the management of behaviour that is challenging including de-escalation techniques. Although some staff were booked to attend these trainings, this was not the case for all who required them.

Judgment: Substantially compliant

## Regulation 22: Insurance

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

Judgment: Compliant

## Regulation 23: Governance and management

There was a clearly-defined management structure in place and evidence of good

oversight in some areas. However, the annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre required improvement to ensure that any issues identified resulted in the generation of actions plans to address these shortcomings, as is required by the regulations. The annual review was also required to involve consultation with the residents.

Clarity was required regarding the staffing levels in the centre and this needed to be clearly documented and communicated to both staff and residents. Consistent application of the provider's person-centred planning processes was also required. Record management practices in the centre needed to be improved. As was found in the last two HIQA inspections, residents' contracts for the provision of services required review and improvement.

Judgment: Substantially compliant

## Regulation 24: Admissions and contract for the provision of services

Written agreements were in place regarding the terms on which residents stayed in the designated centre. However these did not include all of the requirements of this regulation. These findings were also identified in the previous two HIQA inspections of this centre.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

This document met the majority of the requirements of this regulation. The statement of purpose required review to accurately reflect the size of the rooms in the centre and the facilities provided.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

Not all uses of restrictive procedures that occurred in the centre were notified to HIQA, as is required by this regulation.

Judgment: Not compliant

## Regulation 34: Complaints procedure

An effective complaints procedure was in place. Information regarding the complaints process was available in an accessible format to aid residents' understanding. A review of the complaints log demonstrated that any complaints made were investigated promptly, measures required for improvement were put in place, and the satisfaction of the complainant was recorded.

Judgment: Compliant

## Regulation 4: Written policies and procedures

Not all of the policies and procedures required to be maintained, as identified in Schedule 5 of the regulations, had been reviewed within the last three years as is required.

Judgment: Substantially compliant

## Quality and safety

Residents reported that they were happy living in the centre. This was consistent with the inspector's observations. Many residents had developed friendships with their peers and enjoyed each other's company. Positive relationships had also been developed with the staff team. Due to the number of residents living in the centre and the facilities provided, some institutional practices such as set mealtimes, restricted access to food and kitchen facilities, and shared bedrooms were implemented in the centre. This was not consistent with the other person-centred practices seen on the day such as opportunities for residents to choose whether they attended day services or not, personalised and homely bedrooms and sitting rooms, regular visits to and from relatives, warm and respectful staff interactions, monthly residents' forums and the implementation of the provider's person-centred planning processes. Many areas of support were delivered to a high standard. However areas for improvement were identified. These are outlined in the remainder of this report.

The inspector reviewed a sample of the residents' assessments and personal plans. These provided guidance to staff members on the various supports to be provided to residents. Information was available regarding residents' personal histories, communication abilities and preferences, supports required for daily living and personal care, and their likes and dislikes. Residents' healthcare needs were well met in the centre. Where a healthcare need had been identified a corresponding

healthcare plan was in place. There was evidence of appointments with medical practitioners including specialist consultants as required. There was also evidence of input from allied health professionals such as physiotherapists and dietitians. Multidisciplinary reviews of residents' personal plans took place annually. Some improvement was required in the area of document management as it was not always possible to tell which plan was current as not all plans were dated, and there was often more than one copy available. It was also difficult to determine if actions such as referrals to health professionals had taken place.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. The inspector reviewed a sample of residents' personal development plans. The implementation and review of these plans was not consistent. It was identified that not all residents had a current plan in place. For some residents there was evidence of regular review and progress in achieving goals. For others, there was no documented review of some goals and limited progress in others. For example, one resident's plan developed in June 2021, included four goals linked to community based activities with a friend. They wished to go for a meal in a restaurant, to the cinema, to go shopping and to stay overnight in a hotel. At the time of this inspection, in June 2022, this resident had gone to the cinema once in May 2022. In 12 months there was no other review or progress noted for these four goals. For another resident, it was noted that a number of goals were carried over from the previous year although some of these were now part of the resident's daily life as opposed to a current personal development goal.

Residents' forums were held monthly in the centre. These appeared to be forums for discussion, with a different topic each month. It was noted in January 2022 that one resident expressed that the centre was too big and they wished to be in a house with four people. As previously outlined the provider had hoped to support some residents to live in the community but had not received the required funding. Although noted in the residents' forum record, this wish was not reflected in this resident's personal development plan. Instead this plan focused on more day-to-day short-term activities such as going shopping and to the hairdresser.

Contact with friends and family was important to the residents in the centre and this was supported by the staff team. Relatives were welcome in the centre and the majority of residents regularly spent time with family members in their homes. A resident spoke with the inspector about a recent holiday they enjoyed with a sibling.

As outlined in the opening section of this report all residents who lived in the designated centre participated in some activities in the day service. Special mention was given to a social farming group that two residents especially enjoyed. The inspector was informed that since the centre had moved to a seven day service, residents now had the opportunity to remain in the designated centre and not attend day services, if that's what they wished. This increased flexibility afforded the residents more opportunities to exercise choice and control regarding their day-to-day activities.

Each resident had a folder with photographs of outings and activities they enjoyed.

The inspector viewed a sample of these. In-house activities included knitting, watching television (including watching a religious service), helping in the kitchen, baking, colouring, using the exercise bike, singing, using a foot spa and having their nails painted. Community based activities included going for a walk, to the cinema, bowling, for a coffee and shopping. One resident had participated in a sponsored run. It was noted that some residents appeared to participate in a larger number and variety of activities. Many of the community based activities were facilitated by day service staff. Management advised that residential staff also supported residents with community-based activities during the day. The inspector was informed that the purpose of the additional staff from 5PM to 10 PM was to facilitate activities. None of the 18 residents left the centre independently and required support from either staff or family members to access their local community. Staff had told the inspector that recent staffing levels negatively impacted on their ability to support residents in activities both in the centre and in their local community, especially at the weekends.

The inspector reviewed the centre's risk register and a sample of residents' individual risk assessments. The scoring of some risk assessments required review as the ratings were not reflective of the risks posed by hazards in this centre. For example, the impact rating regarding the risk of potential harm to residents due to behaviours of concern was not consistent with the presentation of any of the residents living in this centre or the records kept of adverse incidents. The ratings of some individual risk assessments also required review. The rationale for some ratings was not always clear. For example one resident's individual COVID-19 infection risk assessment had been rated as low. It was not clear why the likelihood and potential impact for them had been assessed as so much lower than that of their peers. Hazards such as staff vacancies and lack of access to mandatory training had not been risk assessed.

Overall the premises were maintained to a very high standard. Residents were encouraged to decorate their bedrooms as they wished. One resident had recently got a new chest of drawers to store their belongings and another was waiting to hang up more photographs. Some areas requiring upkeep were identified during the inspection. These included damaged seals on a floor and other bathroom fittings and a damaged mirror. It was also noted that a number of privacy screens required cleaning.

The inspector reviewed the systems in place regarding the prevention and control of healthcare associated infections, including COVID-19. Information regarding COVID-19 was available in the centre and included the most recent guidance issued by public health. A self-assessment regarding planning and infection prevention and control (IPC) had been recently reviewed. IPC audits was also completed in the centre. Staff had completed IPC training. Two hand hygiene assessors worked in this centre. Records indicated that all members of the staff team's hand hygiene practices had been assessed in the previous six months. The inspector reviewed the COVID-19 contingency plan in place. This document was comprehensive and included learning from outbreaks that had occurred in the centre. Revision was required to ensure that the staffing hours included were accurate and to include guidance for staff should a resident who shared a bedroom be suspected or

confirmed to have COVID-19.

As outlined previously, the centre was observed to be clean on the day of inspection. However some damaged surfaces were observed throughout the centre. These included a wardrobe in one bedroom and some bathroom fittings. As a result it would not be possible to effectively clean these surfaces. Cleaning schedules were in place and there was one staff member working in the centre from Monday to Friday with responsibility for these duties. The staff team were responsible for cleaning at the weekends. The utility room was used for the storage of cleaning equipment, some household items and laundry facilities. Additional products were available in a nearby store room. The utility room was well organised with a clear system in place for the use of specific colour-coded cleaning equipment so as to prevent cross contamination between different areas. A system was in place to ensure there was no mixing of clean items and those that needed to be washed, and also to separate laundry from different areas in the centre. A poster regarding the colour-coded system was on display and information was also available regarding the residents and their laundry needs, for example, their preferences regarding their level of involvement in managing their own laundry.

The premises had fire safety systems including a fire alarm, emergency lighting and fire extinguishers while measures had also been taken relating to fire containment in order to prevent the spread of fire and smoke. The fire systems were being serviced regularly by external contractors to ensure they were in proper working order. As outlined in the opening section of this report, some fire doors in the centre required review. Each resident had a personal emergency evacuation plan (PEEP). Fire drills took place regularly in the centre. The inspector reviewed the records of these drills. It was noted that no drill had taken place with minimum staffing levels, in night time conditions when all of the residents were in the centre. It had therefore not been demonstrated that staff could safely support all residents to evacuate the centre and be brought to safe locations, as is required by the regulations. Management committed to completing a drill to address this shortcoming. It was also noted that there was limited information recorded on the drill records. For example, the location of the fire was not specified, nor the exits used by residents.

The provider had prepared a guide with information regarding the designated centre for the residents, as is required by the regulations. When reviewing this, it was identified that additional information was required regarding the arrangements in place for residents' involvement in the running of the centre. It also required review to ensure that the staffing levels outlined were accurate.

## Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents had opportunities to participate in activities in line with interests and to attend the adjacent day service during the week.

Judgment: Compliant

## Regulation 17: Premises

The premises were clean and decorated in a homely manner. Residents had sufficient storage for their belongings. Maintenance was required in some areas and privacy screens in shared bedrooms required cleaning. The centre was accessible to all residents.

Judgment: Substantially compliant

## Regulation 18: Food and nutrition

The food provided in the centre was nutritious. Residents were offered and supported to make choices at meal times. Some residents participated in snack preparation or baking. Staff had a good understanding and awareness of residents' dietary needs.

Judgment: Compliant

## Regulation 20: Information for residents

The guide prepared in respect of the designated centre required review to ensure that it accurately reflected the staffing levels provided in the centre and outlined the arrangements in place for residents' involvement in the running of the centre.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

The scoring of some risk assessments required review as the ratings were not reflective of the risk posed by identified hazards in the centre. Not all hazards in the centre, such as staffing vacancies and lack of access to mandatory training had been risk assessed.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare associated infections including COVID-19. The outbreak management plans in place required review to ensure they addressed the possible scenario of a resident who shared a bedroom being suspected or confirmed to have a COVID-19 infection. Although the centre was observed to be clean, there were some damaged surfaces, most notably in bathrooms. As a result it would not be possible to effectively clean these surfaces.

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. These systems were serviced and monitored. A review of some of the fire doors was required to ensure they would still be effective containment measures if required in the event of a fire. Although one evacuation drill in night time conditions had been completed in the last year, it did not involve the centre's usual overnight staffing levels and the current occupancy level of the centre.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs of each resident had been completed. Each resident had a personal plan. Improvements were required in the implementation of the provider's person-centred planning processes. Not all residents had a current personal development plan. Personal development were not always reflective of residents' expressed wishes, for example to live in a house in the community. Review and progress in achieving residents' goals was inconsistent. There was often no plan in place or person responsible to support residents in

achieving their goals. There was evidence that goals were carried over from previous years.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners and allied health professionals as required.

Judgment: Compliant

## Regulation 8: Protection

There were no current safeguarding concerns in the centre at the time of this inspection. All staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

## Regulation 9: Residents' rights

There was evidence that staff sought to support residents to develop their independence, make choices and exercise their rights. However due to the institutional practices implemented in the centre there were limits placed on residents' opportunities to exercise choice and control in their daily life and their privacy in their personal and 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 | Compliant |
| Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities | Compliant |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Not compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 24: Admissions and contract for the provision of services | Substantially compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| Regulation 4: Written policies and procedures | Substantially compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 20: Information for residents | Substantially compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 27: Protection against infection | Substantially compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |

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| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for East County Cork 1 OSV-0003305

## Inspection ID: MON-0027736

## Date of inspection: 10/06/2022

**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** |
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| Regulation 15: Staffing | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>The HR manager in conjunction with the Person in Charge and PPIM will review the staffing allocation for the designated centre. To be completed by 30.09.22<br><br>• Meetings will be held between the PIC/PPIM quarterly in 2022 / 2023(or more often if required) to ensure that any known upcoming vacancies can be planned for. The meetings will also focus on effective rostering, holiday allocation and skill mix.<br><br>• The SOP and residents guide has been updated to reflect the correct staffing allocation. Completed on 17.08.22.<br><br>• The PIC will have a copy of the staffing rota available which will reflect staffing allocation 19.08.22 | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>• All staff have completed fire training - 28.07.22<br>• Six staff will have completed Positive Behavior Support training by 04.10.22<br>• The PIC will update the training matrix to reflect booked training dates and will be reviewed monthly 30.08.22.<br>• Manual handling: five staff booked for training on 17.08.22. Plan for outstanding staff to have completed training by 18.12.22. | |

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| Regulation 23: Governance and management | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Allocation of staffing levels in the designated centre will be communicated to all staff by 19.08.22. At a residents forum staffing levels will also be discussed with residents 17.08.22. Staffing levels will also be updated in the residents' guide. Completed - 17.08.22.

• The registered provider shall ensure that the annual reviews will reflect consultation with residents. To be completed at the next review 31.11.22

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| Regulation 24: Admissions and contract for the provision of services | Substantially Compliant |

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

• The PPIM will discuss contracts of care with the management team and amend contracts. To be completed by 31.12.22

• The Administration Team will update financial assessments for each resident. To be completed by 30.09.22.

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| Regulation 3: Statement of purpose | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

• The statement of purpose was reviewed to accurately reflect the size of the rooms in the centre and the facilities provided. Completed on 11.08.22

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| Regulation 31: Notification of incidents | Not Compliant |
| Outline how you are going to come into compliance with Regulation 31: Notification of incidents:<br>• All exit door alarms have been disabled. Completed 20.07.22<br>• The PIC will ensure that all quarterly notifications are submitted in a timely manner in relation to all incidents occurring in the centre and also any occasion in which a restrictive practice was implemented. To be completed in next scheduled quarterly 31.10.22 | |
| Regulation 4: Written policies and procedures | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:<br>• A policy and procedures committee forum has recommenced the review of all policies within the organisation. Policy review to be completed by 31. 12.22 | |
| Regulation 17: Premises | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>• The PIC has updated the cleaning schedule to reflect weekly cleaning of privacy screens. Completed on 15.08.22<br>• The PIC and PPIM have completed a walk around of the premises. Identified maintenance will be completed by 15.11.22 | |
| Regulation 20: Information for residents | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 20: Information for residents:<br>• The Residents Guide will be updated by the PIC in conjunction with the residents to reflect their involvement in the running of the designated centre. Completed 17.08.22 | |

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| Regulation 26: Risk management procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The PIC will review the risk register and individual risk assessments taking into consideration risk rates. To be completed by 30.10.22
• The PIC will risk assess and add to the risk register identified staffing levels and staff training as a priority. To be completed by 30.09.22

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| Regulation 27: Protection against infection | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The PIC will update the contingency plan to reflect a system to prevent and control associated infections which will include an isolation area for residents who share a bedroom in the event of suspect or confirmed COVID -19. To be completed by 31.08.22
• Identified maintenance which include damaged surfaces and flooring have been escalated to the Facilities manager to be completed by 15.11.22

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| Regulation 28: Fire precautions | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.
• All fire doors within the residence have been assessed and repaired where necessary to ensure ther effectiveness in the event of a fire. Completed on 23.08.22
• The PIC has created a document to record fire drills which records the source of the fire, time to evacuate each resident and comment for issues of concern. All staff have been informed of the recording system at a staff meeting on 05.08.22.
• An assessment was completed by the local fire station to further support night time evacuation on 03.08.22.

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| • A staff from the team has been identified to review the fire book and documentation monthly. Completed on 03.08.22<br>• A night time fire drill was completed with night staff on 28.07.22 at 21.30. A schedule of fire drills has been compiled by the PIC which include day and night time fire drills.<br>• A residents forum will be held to support residents' awareness of the procedure to follow in the event of a fire. To be completed on 25.08.22. |

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| Regulation 5: Individual assessment and personal plan | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:<br>• The PIC will schedule a person -centred planning meeting for each resident. The PIC has identified a key worker system which will support goals which are meaningful to the person. To be completed by 31.10.22.<br>• The PIC will audit bi – monthly the person centred process to ensure goals identified are implemented and documented using the S.M.A.R.T goal process. Tthis will commence on 31.10.22 | |

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| Regulation 9: Residents' rights | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 9: Residents' rights:<br>• A staff member has been identified to support the residents forum. Residents will have the opportunity to make choices and decisions about their daily lives. This will be a scheduled topic for discussion. To be completed by 31.08.22.<br>• The Chief Operations Officer and PPIM will discuss the Business Case submitted to the HSE at the next Operations Meeting 30.09.22. This business case advocates for four people to move out to a residence in the community. | |

## 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 |
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| Regulation 15(1) | The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. | Not Compliant | Orange | 30/09/2022 |
| Regulation 15(4) | The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained. | Not Compliant | Orange | 19/08/2022 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, | Substantially Compliant | Yellow | 18/12/2022 |

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| | as part of a continuous professional development programme. | | | |
| 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 | 15/11/2022 |
| Regulation 20(2)(c) | The guide prepared under paragraph (1) shall include arrangements for resident involvement in the running of the centre. | Substantially Compliant | Yellow | 17/08/2022 |
| 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. | Substantially Compliant | Yellow | 17/08/2022 |
| 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. | Substantially Compliant | Yellow | 30/11/2022 |

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| 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 | 15/10/2022 |
| Regulation 24(4)(a) | The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged. | Substantially Compliant | Yellow | 30/09/2022 |
| Regulation 26(2) | The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and | Substantially Compliant | Yellow | 30/10/2022 |

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| | ongoing review of 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 | 31/08/2022 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Substantially Compliant | Yellow | 03/08/2022 |
| Regulation 28(4)(b) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Substantially Compliant | Yellow | 28/07/2022 |
| Regulation 03(1) | The registered | Substantially | Yellow | 11/08/2022 |

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| | provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Compliant | | |
| 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 | 31/10/2022 |
| Regulation 04(3) | The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice. | Substantially Compliant | Yellow | 31/12/2022 |
| Regulation 05(4)(b) | The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, | Substantially Compliant | Yellow | 30/09/2022 |

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| | prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes. | | | |
| 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. | Substantially Compliant | Yellow | 30/09/2022 |
| 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. | Substantially Compliant | Yellow | 31/10/2022 |
| Regulation 05(7)(c) | The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and | Substantially Compliant | Yellow | 31/10/2022 |

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| | shall include the names of those responsible for pursuing objectives in the plan within agreed timescales. | | | |
| Regulation 09(2)(b) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life. | Substantially Compliant | Yellow | 31/10/2022 |
| 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 | 31/08/2022 |