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 15
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	20 November 2024
Centre ID:	OSV-0005395
Fieldwork ID:	MON-0044555

About the designated centre

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

Cork City North 15 is comprised of three purpose-built bungalows which are located within a secure campus setting adjacent to another designated centre and a day activation centre on the outskirts of Cork city. The designated centre can provide full residential care for up to 17 adult residents. Two bungalows are comprised of six individual bedrooms, kitchen, dining and sitting room, music room, laundry and linen room. Each bungalow also has two shared bathrooms and an additional toilet for residents to use. There is a connecting corridor between two bungalows where a staff office and facilities are located. The third bungalow has been restructured to create one self-contained apartment styled dwelling to support one resident and the rest of the bungalow can support a maximum of four residents. The centre supports residents with mild, moderate and severe/profound levels of intellectual disability with many residents presenting with additional complex needs and behaviours that challenge. Residents are supported by a staff team that comprises of both nursing and social care staff by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 20 November 2024	09:45hrs to 17:20hrs	Elaine McKeown	Lead
Wednesday 20 November 2024	09:45hrs to 17:20hrs	Conor Dennehy	Support
Friday 22 November 2024	16:15hrs to 16:55hrs	Lisa Redmond	Support

What residents told us and what inspectors observed

This was an un-announced inspection completed within the designated centre Cork City North 15. The designated centre was registered with a maximum capacity of 17 adults. It was comprised of three purpose built bungalows located on a campus setting. All three bungalows were located close together on the same grounds as a day services building. Two of these bungalows were interconnected while the third bungalow was interconnected to another bungalow that was part of another centre operated by the same provider. Two of the bungalows had a capacity for six residents each while the third bungalow was made up of main area for four residents and an apartment for one resident. At the time of the inspection 13 residents were in receipt of services which included one resident in receipt of shared care arrangements. The inspectors who visited all three of the bungalows met with nine of the residents during the inspection.

The designated centre had previously been inspected in September 2023. There had been a number of actions identified during that inspection that required a non - standard condition of registration to be added to the renewal of the designated centre's current registration cycle which began on 28 February 2024. The provider is to address the regulatory non-compliance to the satisfaction of the Chief Inspector not later than 31 December 2026. This focused inspection was conducted to monitor the quality of life for residents and progress being made by the provider to address issues identified in the previous inspection. The inspectors acknowledge that there were some positive outcomes evident during the inspection which included a large reduction in the staff vacancies resulting in more consistent staffing supports for the residents in recent months.

The inspectors visited all three bungalows at the start of the inspection. On arrival at one of these bungalows, an inspector was introduced to one resident as they were having their breakfast. This resident, who did not communicate verbally, did not interact with the inspector at this time and soon after left the bungalow to attend the nearby day services where they spent much of the inspection day. Near the end of the inspection, the same inspector briefly met this resident again in the bungalow’s living room after they had returned from day service. Again, the resident did not interact with the inspector but seemed content in the presence of staff in the same room.

The same inspector met two other residents living in this bungalow. Initially, at the start of the inspection, the inspector was informed that it might not be the best time to meet one of these residents who lived in the apartment area of the bungalow. However, later on when the inspector checked with staff, it was indicated that the inspector could meet the resident then. The inspector was accompanied into the apartment by a member of staff who then advised that the resident was finishing a meal in the apartment’s living room. As such to ensure an uninterrupted mealtime,

the staff member and the inspector waited until the resident had finished their meal in the company of a second staff member.

Once the resident had finished their meal they greeted the inspector with a handshake. They were then observed to return to their living room where they lay down on a couch. They were wearing festive clothing and noted to be humming seasonal songs.The resident did not interact verbally with the inspector at this time but did shake the inspector's hand on two more occasions. It was seen also that the resident seemed comfortable in the presence of the staff present when the inspector was in the apartment.

The inspector was aware the third resident living in this bungalow had only recently moved in having previously lived in other designated centres operated by the provider. This resident chatted to the inspector and mentioned recently moving into the bungalow as well as speaking openly about their health. The resident said that they did not know how long they were going to be living in the bungalow. They also felt that they were not being told anything. The inspectors acknowledge that a planned case conference did take place on the day of the inspection. Despite this, the resident did say that they knew the staff working with them and was observed to interact very jovially with a staff member present. Such interactions indicated that this staff member and the resident were familiar with one another and there appeared to be a warm relationship between them.

At various points during the inspector's time in this bungalow, this resident referred to them not having a television in the bedroom. On one such occasion, the resident told the inspector that they owned a television which had cost €900 but this television was still in the designated centre where the resident had lived immediately before moving to this centre. This was later queried with management of the campus, who indicated that the television the resident was referring to was the property of the provider and not the resident. The inspectors acknowledge that the staff team made efforts to resolve the issue to the satisfaction of the resident with a new television made available to the resident before the end of the inspection.

However, an inspector observed a person employed by the provider but was not a member of the management or front line staff team who delivered the television, twice enter the bungalow where the resident lived without knocking on any door or announcing themselves. This included one instance where the person entered the bungalow through the apartment area when the resident living there was laying down on their bed with their bedroom door open. As this bungalow was a home for three residents, this had the potential to impact residents' privacy although management of the campus indicted that residents would be familiar with this person. Aside from this in the dining room of the bungalow's main area, the inspector observed a white board that had personal information relating to residents written on it. This included details of upcoming medical appointments for two residents. The display of such information in a communal area did not respect residents' privacy.

There were three residents introduced to another inspector in the second house that was visited. Two residents were in the dining room. One explained to the inspector

that they were getting ready to attend their day service on the same campus. They spoke about their favourite football team as they were wearing some clothing with the team's logo. They had a haircut the day before and due to the cold weather spoke of needing a hat. They informed the inspector they were happy attending their day service every day and enjoyed many different activities including out in the community with social activities such as bowling.

The other resident was self-propelling themselves around in their wheelchair. They were distracted by the inspector's presence from finishing their breakfast so the inspector returned later in the morning to meet them again. They were resting on their bed at that time. It was evident they had been supported with their personal care and staff outlined the plans to take the resident with other peers out for a social activity. The third resident was observed to be smiling as they walked along the hallway.They did not engage or acknowledge the inspector but was observed to be relaxed in the company of their peers and the staff on duty.

Six residents lived in the third bungalow. However, when an inspector visited, two had already left to attend the day service on the same campus and were not met with during the inspection. Two other residents were introduced by staff to the inspector as they lay on couches in the large sitting room. One of the staff supporting the residents outlined the importance of being familiar with the assessed needs of the residents living in the house and relevant behaviour support plans to ensure the well being and safeguarding of all those living there. This included restrictive practices such as locked doors and clear guidelines for staff regarding the frequency of when a named resident could be supported to have their preferred hot drink. Staff were aware of the rationale to ensure the effectiveness of this support plan. However, while another staff member outlined the specific protocol required by one resident regarding the administration of their medications this was not evident to have been documented in the resident's health plan, personal plan or in their current prescription of medicines.

This resident was resting in bed when the inspector first visited but was introduced later in the morning when the inspector returned. The staff team outlined the required staffing supports that the resident was provided with. This included 1:1 staff support during the day. This was observed to be in place during the inspection. The resident was watching television and the staff member outlined how the resident indicated their choice and preference with gestures and vocalisations. Activity records reviewed for the resident were limited in the details but did reflect regular walks and spins. This will be further discussed in the quality and safety section of this report.

One inspector was informed early on in the inspection that a review was taking place regarding the location of a bedroom in one of the houses. The resident who had been recently transferred had reported to staff they were being adversely impacted by the noise being made by a peer at night time. While the atmosphere in the bungalow on the day of inspection was quiet, when reviewing records in the bungalow, an inspector saw reference to two recent instances which suggested this was not always the case. The first involved one resident being woken at intervals

during the night while the second involved the same resident being kept awake throughout a different night due to the presentation of a peer on both instances.

The two instances had occurred in the days before this inspection and the resident impacted had been supported to make a complaint following the second instance. While the compliant was not resolved at the time of this inspection, inspectors were informed that it had been discussed at a case review on the day of inspection. However, in discussions with a staff member it was suggested that the resident impacted had recently said that they were afraid of the other resident involved. When inspectors queried this with management of the campus, it was indicated that such matters had not been referred to the provider's designated officer (person who reviews safeguarding concerns) but that when making their compliant, the resident impacted had not made any reference to them being afraid. At the feedback meeting at the end of the first day of the inspection management outlined that consideration for the future provision of services to the resident was still in progress. Further consultations with the resident and their medical team were being scheduled to ensure the assessed and changing needs of the resident would be effectively supported.

All residents had their own bedrooms and ample communal space available in each of the three houses. While there was evidence of regular cleaning taking place throughout the designated centre, some items of furniture were observed to be badly damaged. This included a couch and a chair in one house which had large amounts of the internal padding exposed. Storage units in one bedroom were observed to have damaged surfaces. The inspectors were informed this issue had already been logged by the staff on the maintenance system prior to the inspection. In addition, general wear and tear was evident on paintwork in some areas. Also, a bathroom door was not in place and there were no curtains in one area of the designated centre. An inspector was informed that such items were removed by a resident and that maintenance requests had been submitted to address these. The provider had a system in place if there were delays in addressing such requests these could be escalated to the person participating in management. The inspectors were informed during the feedback meeting that funding had been secured and allocated to the designated centre to purchase new furniture.

While inspectors did not review in full Regulation 28 Fire precautions, during the walk around of one of the houses it was evident some fire safety practices were not consistently being adhered to by staff. As per the findings on the previous two inspections in this designated centre, effective fire containment measures were not consistently maintained in some areas of the designated centre. An extension panel on a bedroom door was observed by one inspector to be opened back to ventilate the bedroom but this did not provide for effective containment measures in the event of the fire alarm activating. In addition, a fire door in an office was observed to be prevented from closing with a chair placed to keep the door in the open position. Staff addressed both issues immediately once brought to their attention.

In summary, the provider had made progress to address the staffing vacancies since the previous inspection in September 2023. While challenges remained, the provider had reduced the reliance on agency staff (staff sourced from an external agency)

There was evidence of a core group of regular staff working in the designated centre, familiar with the assessed needs of the residents for whom they were supporting. In addition, more transport vehicles were available with additional drivers on the staff team. Residents within the designated centre were being supported to engage more frequently on a rotational basis in meaningful activities. There was evidence of co-ordinated approaches between the three houses and staff team to support small group activities to enable social outings. The inspectors acknowledge the provider had commissioned a service improvement team and a system analysis review within the designated centre to identify and address issues specific to the designated centre. There was documented evidence of ongoing meetings and updates.These will be further discussed in the next two sections of this report. However, on the day of the inspection, effective fire containment measures were not evident in at least one house, the awareness of some staff members to ensuring containment measures were consistently in place was not demonstrated on the day of the inspection. This was the third consecutive inspection of this designated centre since May 2023 where issues relating to fire containment measures were found not to be in place. There were also gaps/delays in reviews taking place for some residents including risk assessments, health care plans and personal plans

The next two sections of this report will 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 provided.

Capacity and capability

Overall, this inspection found that there was evidence of progress and improvements being made in the care and support being provided from a core consistent staff team to the residents. This resulted in some positive outcomes for residents in relation to engaging more frequently in activities in the designated centre and in the community. There was evidence of oversight and monitoring in management systems that were in place with planned changes already commenced by the provider ensuring the residents received a good quality and safe service.

The provider was aware of the regulatory requirements to complete an annual review and internal provider led audits every six months in the designated centre. While an annual review had been completed for the designated centre reflecting on the service provision during 2023 only one provider-led internal six monthly audit had been completed in the previous 12 months. This had been completed in February 2024. There was documented evidence of updates and progress being made on actions identified in that audit. However, in-lieu of the second six monthly

provider led audit for 2024, the provider had undertaken a detailed review of the services being provided in this designated centre during August 2024.

The provider had commissioned a service improvement team which included representatives from management, nursing (including assistant directors of nursing and nurse tutors), advocacy and employment relations departments to review the services being provided within the campus where this designated centre was located. A comprehensive review was undertaken which included reviewing the safety and quality of life for residents in receipt of services, staffing issues and the findings of audits already completed within the designated centre. This resulted in a detailed action plan with time lines and persons responsible identified. The service improvement team met weekly from August to October 2024 with updates documented. The provider's executive team was kept updated frequently on the findings and actions planned. For example, in September 2024, a staff mapping exercise was completed in each house, local management were a visible presence in each of the houses daily and a review of the night shift patterns was undertaken. Other actions identified and completed were a review of the role, job descriptions and responsibilities of all nursing grades and health care assistants. In addition, a weekly report was required to be submitted by the person in charge to the chief executive officer regarding the ongoing review of services being provided in the designated centre.

The inspectors were informed as part of the review process the voice and opinion of the staff team was included. Staff were asked if they had any talents, special interests or courses completed which they would be interested in sharing with the residents and other members of the staff team to enhance experiences and opportunities for learning new skills for residents. Some staff had informed the team of interests in vintage cars, art, baking and cookery. The inspectors were informed staff would be encouraged to consider sharing these interests with residents as part of offering increased choices in their planned activities.

Since the start of November 2024 the service improvement team were meeting fortnightly with planned actions outlined which contained time lines for implementation and the person who was responsible. This included the planned commencement of clinical supervision of all nursing grades within the designated centre during November 2024. A pilot programme of performance achievements was also planned to be implemented for the staff team as part of the supervision process.

The provider had also requested a systems analysis review be completed following an incident that occurred in one of the houses in June 2024. The Chief Inspector had been notified by the provider as required by the regulations of the incident. A resident had become unwell and experienced a rapid deterioration in their condition. Emergency services were contacted but the resident died in the designated centre. The inspectors acknowledge there was an impact experienced by the residents and staff team in the house during and following the incident. The director of nursing and the provider's quality and safety adviser conducted the review. While the report had not been finalised at the time of this inspection, the provider had been given a draft copy which was provided to the inspectors to review during the inspection. A

number of recommendations were contained within the draft which included a full review of all residents personal plans and medical files to ensure all information was up-to-date. This is consistent with some of the findings during this inspection and will be further discussed in the quality and safety section of this report.

The person in charge was not available on the day of the inspection. The person participating in management, a clinical nurse manager and other members of the staff team did facilitate the inspection which included providing additional information and making all documents requested for review by the inspectors available in a timely manner.

Regulation 15: Staffing

The person in charge had ensured there was an actual and planned rota in place. Changes required to be made to the rota in the event of unplanned absences or scheduled training were found to be accurately reflected in the actual rota. In addition, staff demonstrated their flexibility in changes to their planned shifts, sometimes at short notice, to support the assessed needs of the residents. Rotas reviewed from 30 September 2024 until the date of inspection indicated that minimum staffing levels in the centre were being maintained in accordance with the centre's statement of purpose.

The previous inspection in September 2023 had highlighted that the number and skill-mix of staff was not being consistently maintained to meet the assessed needs of residents. There were 6.5 whole time equivalent (WTE) staff vacancies in this designated centre at that time. During the current inspection, inspectors were informed that the number of staff vacancies had decreased to 1.4 WTE vacancies and that the use of agency staff had also reduced. These were described as positive developments and staff spoken with indicated that staffing in the centre had improved in recent times. Inspectors were informed the recruitment of an activation staff member was underway at the time of the inspection. The role would be one WTE but the rostering of the hours would be flexible to suit the assessed needs and activity choices of the residents including evenings and weekends.

The inspectors were aware that there had been a reduction in the number of residents living in the centre in recent months which also impacted on the demands on the staff team. Aside from this, staff rotas were now being kept specific to this centre rather than be shared with another centre on the campus, as had been the case previously.

It was seen though that the stated figure for minimum night staff in the centre's statement of purpose required review for clarity while the rotas reviewed did not set out the hours that the person in charge worked. Aside from staff rotas, under this regulation specific documentation relating to all staff working in a centre must be obtained. This documentation includes written references, full employment histories, evidence of registration with professional bodies, and evidence of Garda Síochána (police) vetting. Such documentation was held centrally by the provider rather than

in this designated centre. As such, while the inspection was initially intended to be a one day inspection, an inspector attended the provider's head office on 22 November 2024 for a brief second day of inspection to review the required documentation. Three staff files were reviewed which were found to contain most of the required documents. It was noted though that evidence of registration with a professional body for one nursing staff member was not in place.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The staff team comprised of a total 28 staff members which included the person in charge, nurses and health care assistants at the time of this inspection. This also included regular relief staff who were familiar to the residents.

However, at the time of the inspection there were gaps in the up-to-date training of staff members which included, 48% of staff required refresher training in fire safety and 43% of staff did not have up-to-date training in safeguarding. While there was training scheduled for safety intervention for 21 staff during December 2024 at the time of the inspection only 10 staff had up-to-date training.

The provider had supported additional training for the staff team since the previous inspection to meet the specific needs of residents within the designated centre which included mental health and autism.

While the inspectors acknowledge information was provided during the inspection relating to the provider actively seeking to implement changes to ensure the effective supervision of the staff team and had advanced plans to meet the regulatory requirements not all staff had been subject to supervision during 2024.These plans included clinical supervision for all nursing grades to commence in the weeks following this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider demonstrated that an extensive review of the the services being provided in this designated centre including the governance and management systems had been under taken and was still in progress at the time of this inspection.

The provider was able to demonstrate progress was being made to attain compliance with the regulations as required by the non-standard condition of registration for this designated centre. This included staff recruitment and actions being taken to ensure the safety and well being of residents.

There were detailed action plans and time lines with documented evidence of regular review and oversight by senior management.

There was evidence of engagement with the staff team and residents to ensure effective supports to meet the assessed and changing needs within the designated centre.

The provider had ensured that findings from recent reports on the safety and quality of care and supports provided in the designated centre were acted upon and plans put in place to address concerns raised.

While not all actions from the previous inspection had been fully addressed at the time of this inspection, the provider demonstrated their commitment to implementing the recommendations and actions identified regarding this designated centre.

However, at the time of this inspection the provider had not implemented effective arrangements to support, develop and performance manage all members of the work-force to exercise their personal and professional responsibility for the quality and safety of services they are delivering. For example, ensuring all staff were aware of their personal and professional responsibility to consistently maintain effective fire containment measures throughout the designated centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Following the previous inspection in September 2023 under Regulation 23: Governance and management the provider had outlined a protocol had been put in place to ensure timely submission of 3-day and other notifications as per the regulatory requirements. This included at times when the person in charge may be absent.

However, inspectors were not assured that all injuries were being submitted to the Chief Inspector in writing as required by the regulation. For example, on 21 July 2024 a resident sustained a head injury after a fall during an epileptic seizure, they required transfer to hospital and investigations were carried out including radiology but this was not reported to the Chief Inspector.

In addition, inspectors were not assured all matters which required notification on a quarterly basis were being consistently submitted to the Chief Inspector. For example, a restriction pertaining to a locked laundry room in one of the houses had

not been reported in the most recently submitted quarterly notification. This had been reported in the previous quarterly notification. However, on the day of the inspection a staff member informed an inspector the restriction was still in place to support the assessed needs of the residents living in the house. This was queried during the feedback meeting and inspectors were informed the restriction was no longer in place but there was no evidence of review or discontinuation of this restriction in the restrictive practice log given to the inspectors to review during the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

During the September 2023 inspection, it had been identified that no complaints had been logged regarding issues that had been raised by some residents' relatives in surveys that had been completed and submitted to the provider. In response, the provider had indicated that the issues raised by such relatives had been logged as complaints and that actions taken to resolve these had been documented. Complaints records reviewed during the current inspection confirmed that this had been done.

However, when reviewing such records an inspector saw a complaint that had been made in October 2022 that involved a relative of the resident living in the apartment in one bungalow raising a concern around this resident becoming isolated. The complaint record indicated that senior management were aware that this apartment was not suitable for the resident. Despite this the complaint was marked as being unresolved and was signed off in October 2023 with reference made to a referral being made for a full multidisciplinary review or assessment of the resident's needs. The complaints record reviewed made no reference to what the outcome of this multidisciplinary review or assessment was or if it happened.

When this was queried with management during the inspection, it was indicated that the resident did have an annual multidisciplinary review in June 2024. Notes of this review were provided but were noted to contain limited information. It was also indicated that the resident involved (along with other residents in the centre), were a high priority for de-congregation away from this campus centre. An inspector did read a record of a recent referral for social work support to assist the resident in pursuing community living. While this referral was noted, inspectors were given no update as to any specific plan to provide this resident with a setting suited to their needs. As such the complaint from October 2022 remained unresolved.

Judgment: Substantially compliant

Quality and safety

Overall, the residents were being supported by a dedicated core staff team at the time of this inspection. There was evidence of review and monitoring of the services being provided with improvements evident in recent months. This included increased support and plans to provide training to the staff team to assist with identifying meaningful and personal goals for residents using a stepped approach to attain such goals.

Some of the findings during this inspection regarding residents personal plans were similar to the findings of the systems analysis review completed in recent months. The report was still in draft format at the time of this inspection. However, one of the recommendations contained within the draft included a full review of all residents personal plans and medical files to ensure all information contained within these support plans were up-to-date. Also, the report outlined a recommendation for staff to ensure all residents had been supported to attend all medical appointments as required.

The provider had supported all members of the staff team to attend training regarding eating, drinking and feeding in May 2024 which was delivered by the speech and language therapist. This was to ensure staff had up-to-date training to support the assessed needs of the residents they were supporting during mealtimes.

During this inspection discussions with staff indicated that residents were supported to maintain relationships with their family members. This included one resident regularly going home to stay with their family. A number of residents attended the day services building located close to this centre while activation staff were also available to support residents to engage in activities. The scheduling of activities for residents generally had improved since the previous inspection. However, it was noted that there was variance in the recording of residents' activities with different activity records kept in the different bungalows within the designated centre. For example, when an inspector requested to review the activity records in one bungalow he was provided with daily handover sheets. While these sheets were sometimes used to record activities that residents did, on some days residents were not recorded as having done any activity in them.

In addition, while a process of person-centred planning was used to identify goals for residents to achieve, it was not being consistently documented if goals were being reviewed or being progressed. For example, one resident had a goal identified in November 2023 to go on an overnight stay away. However, no time-frame or responsibility had been assigned for this goal and it was not documented what, if any progress, had been made with this goal. When queried with staff during the inspection, it was indicated that this resident had not gone on an overnight stay away although it was acknowledged that the resident had been supported to participate in job shadowing at a train station during 2024. For another resident, who had been availing of services in the centre since September 2023, no person-centred planning process had been completed for the resident in this designated

centre. An inspector was informed though that goals for this resident were being worked on through the resident's day service.

Regulation 10: Communication

This regulation was not reviewed in full during this inspection. However, when reviewing the personal plan of one resident it was seen that multiple documents contained within this on supporting the resident to communicate made explicit reference to two particular means of communication that the resident used. However, in discussions with two different staff members around how the resident communicated, no reference was made to either means of communication. A member of campus management indicted also that the resident did not use one of these means of communication. Such information indicated that staff were either unaware of the communication methods used by the resident or the communication documentation in the resident's personal plan was inaccurate.

Judgment: Substantially compliant

Regulation 17: Premises

The provider had systems in place for staff to identify and log issues pertaining to the premises and general maintenance. While parts of the designated centre visited were seen to be clean and reasonably presented, a number of maintenance issues were observed during the inspection. These included:

- Walls being marked or chipped
- Skirting boards being marked
- A bathroom missing it's door
- Damaged seating with exposed internal materials
- Damaged under sink units in a bedroom, the inspectors were informed at the end of the inspection this issue had been logged on the provider's maintenance system.

The inspectors acknowledge that they were informed funding had been made available for new furniture to be purchased in the weeks and months following this inspection

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had ensured there had been regular review of measures and controls in place for risks within the designated centre. The most recent review had been completed in September 2024.

However, when reviewing the personal plans of individual residents, it was seen that they contained risk assessments relating to identified risks, specific to individual residents. Such risk assessments described the risks and outlined specific control measures to mitigate against these risks. Despite this, it was noted that a number of these risk assessments had not been reviewed in over 12 months. For example, one resident's risk assessment was last marked as having been reviewed in March 2023. In addition, a management plan related to an identified risk for another resident indicated that an environmental checklist was to be carried out every day. However, when an inspector requested to review such checklists, a staff member was unaware of them and none were provided during the inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

This regulation was not reviewed in full during this inspection. However, an obstruction was observed to be in place holding an office door open and an extension panel on a bedroom door was observed to be opened back to ventilate the bedroom during the walk around of one of the buildings in the designated centre. These prevented effective containment measures to be in place in the event that the fire alarm was activated. Staff addressed the issues once brought to their attention by closing both doors. This was the third consecutive inspection since May 2023 where ineffective fire containment measures were identified by inspectors. This was discussed during the feedback meeting at the end of day one of this inspection

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

This regulation was not reviewed in full during this inspection. However, one resident, who was diagnosed with epilepsy, was prescribed specific PRN medicines (medicines only taken as the need arises). When these PRN medicines were to be administered depended on the type and duration of particular seizures experienced by the resident. Despite this, staff spoken with gave varying information as when these PRN medicines were to be given. Although one of these staff members

indicated that information about when to administer these was written down, different information was documented around this between the resident's prescription records, PRN protocols and epilepsy management plan.

Staff outlined to an inspector a protocol in place to support another resident when being administered their medications. The inspector was informed this required the resident to have their medications administered in a particular way and contained in a particular food. However, there was no documentation/information to ensure consistency in the approach used by staff available for the inspector to review regarding this protocol

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident in receipt of services in the designated centre did have a personal plan in place, which are intended to identify the health, personal and social needs of residents while also providing guidance for staff on how to meet these needs. The inspectors acknowledge that recommendations had been made by a review group commissioned by the provider for a full review of all personal plans.

During the inspection, the personal plans of five residents were reviewed by inspectors. These plans were found to contain some recently reviewed guidance on supporting residents in various areas while there was also documented evidence of annual multidisciplinary reviews taking place. However, some areas were identified which needed improvement from the personal plans reviewed, such as:

- One resident's documentation made reference to them needing full assistance with aspects of their personal care although a post-it note attached to the resident's personal plan indicated that this was inaccurate.The same resident's health assessment was dated from July 2024 but upon review the majority of this assessment had not been completed. The resident's healthcare plans had not been reviewed since October 2023 even though it was indicated that such plans were to be reviewed every six months.
- A healthcare plan for one resident, which had been initially compiled in June 2022 and review two days before this inspection, indicated that monthly observations for the resident were to be done. Despite this a log for recording such observations only had entries for four months in 2024 with two of these recording the resident's weight only. When queried with management during the inspection, it was suggested that the resident might have refused the observations on other months but this was not documented on the log.
- The progression of goals was not evident in some personal plans. For example, a resident was to attend swimming but there was no evidence if this activity had taken place and the goal achieved

- Another resident had been supported to have an overnight break in another town in December 2023, but no details of progress being made to attain two other long term goals that had been documented for the resident.
- Activity records within the designated centre were being used inconsistently by staff. The description of the activities were limited at times and staff were using two different templates at the time of this inspection to record activities which residents engaged in.
- Not all personal plans had been subject to an annual review with a post-it on one resident's file for the review to be completed by mid -December 2024, the previous review had taken place in August 2023.
- One resident in receipt of services since since September 2023 did not have a person -centre planning process completed.
- One resident's safeguarding plan had not been reviewed since February 2022 but made explicit reference to the resident remaining under 1:1 staff supervision. While the resident did receive support from staff at times on a 1:1 basis, their living arrangements had changed since February 2022 which meant that they were not receiving 1:1 staff supervision at the time of this inspection.

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Judgment: Not compliant

Regulation 7: Positive behavioural support

Specific support plans were available for staff which provided guidance and information on how to encourage residents to engage in positive behaviour. Inspectors reviewed three of these plans and noted that they contained a good level of information around supporting residents in this area. Staff spoken with demonstrated a good awareness of the contents of these plans. This included consistent supports for one resident regarding their consumption of a hot drink which was reflective of the information provided to the inspector when they were introduced to the resident.

The person in charge had ensured restrictive practices within the designated centre had been subject to regular review. However, a restriction where a door was locked into a laundry room in one of the buildings had not been reported in the most recent quarterly notification. When this was discussed during the inspection, it was reported this restriction was no longer in use. However, a staff member in the house informed the inspector it was still in use and there was no documentation to reflect if/when this restriction had been discontinued. This required further review to ensure consistency within the staff team. This has been actioned under Regulation 31: Notification of incidents

Judgment: Compliant

Regulation 8: Protection

The inspectors were informed there was one active safeguarding plan for a resident in the designated centre at the start of the inspection. This safeguarding plan had not been reviewed since February 2022 and was not reflective of the current living arrangements and staffing supports in place for the resident. This has been actioned under Regulation 5: Individual assessment and personal plan.

When reviewing residents' personal plans, it was seen that each contained general safeguarding plans outlining measures to ensure the safety of residents. However, such plans were found to need updating and/or review. For example, these safeguarding plans made specific reference to all staff completing particular training even though this training was no longer being provided for staff of this centre. This has been actioned under Regulation 5: Individual assessment and personal plan.

Not all staff had up-to-date training in safeguarding at the time of this inspection. This will be actioned under Regulation 16: Training and development

Judgment: Compliant

Regulation 9: Residents' rights

Throughout this inspection, staff on duty were seen to interact with residents with a pleasant and respectful manner. Inspectors were also informed that work was ongoing to make consultation with residents more meaningful.

Residents had been supported to avail of the services of an independent advocate.

Some areas were noted though where the privacy of residents could be better protected and promoted. These were:

- A white board in a communal area in one bungalow contained personal information related to individual residents.
- A person, who was not a front-line member of staff or management, was seen to twice enter once bungalow without knocking or announcing themselves first

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 15 OSV-0005395

Inspection ID: MON-0044555

Date of inspection: 22/11/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Recruitment is ongoing to fill vacancies in the centre including recruitment of one activation staff. Role / job description has been drawn up and posts were advertised (w/c 7th October 2024). One successful candidate, progressing to contracting. • Review of staff, assigned to CCN15, who are currently on long term leave underway in conjunction with HR. • Weekly working hours of the PIC have now been clarified on the centre's roster. • The centre's statement of purpose has been reviewed by the PIC and PPIM to clarify minimum requirement for night staff in the centre. Updated SOP will be submitted to HIQA by 31.01.2025. • Outstanding nursing staff's professional registration has been received by the PIC and submitted to HR for filing.	
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 PIC will allocate protected time going forward for staff to complete mandatory online training. • All staff scheduled to complete safeguarding training by 31/03/2025. • The PIC met with Designated Officer (DO) on 19.12.2024 and requested in person safeguarding discussions / information sessions for staff. Two sessions scheduled in 2025 with aim for completion by 28/02/2025.	

• ADON is currently seeking dates for Mental health training.
Performance achievement underway with staff with clear goals set out for all staff

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A pilot of the new Horizons Performance Achievement process was introduced in CCN15 in October 2024. This has been very successful and feedback from staff and management very positive. From October 2024, the cycle of Performance Achievement (P.A) meetings commenced with all staff having individual P.A meetings with managment.
In addition, in line with the NMPDU Personal Development Planning framework, Clinical Supervision for nursing staff will commence in CCN15 in January 2025. Led by the ADONs, this will involve ADONs providing clinical supervision to more senior nursing staff, with senior nursing staff providing clinical supervision to staff nurses.
In relation to improving standards and professional behaviour with regard to fire safety, Q1 will see the introduction of a standardise Fire Safety Protocol, developed by Work stream 6 (Estates) of the Quality and Continuous Improvement Programme.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
PICS and senior nursing staff now have access to NIMS and a new standardized protocol for the Notification of Incidents has just been finalized by Work stream 2 (Quality, Safety and Risk Management) of the Quality and Continuous Improvement Programme (QCIP).
In addition, work stream 2 are finalizing an excel based system which will assist PICS with triangulation of reporting (NIMS, regulatory, safeguarding) to ensure accurate monitoring or all reporting requirements. This will be ready no later than February 2025.
Terms of Reference have been recently agreed for the CCN15 Quality and Safety Committee, which will have it's first meeting by 31.1.25, and will meet quarterly thereafter.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints process has been reviewed and updated within the designated centre.
• New complaints process is operating effectively within the centre. PIC has full oversight of complaints. PIC has reviewed unresolved complaints and updated the complaints log with additional information.
• Work stream 2 of the QCIP has developed an updated complaints log to assist PICs, with an associated updated complaints form. This will be introduced to CCN15 in Q1 2025.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• Referral for SLT review has been submitted for one resident.
• Communication methods and documentation to be reviewed with the resident, staff and in conjunction with SLT to ensure that all staff supporting this resident are aware of their communication style and methods.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Requests for all issues identified during the inspection have been logged on the providers internal maintenance request system.
• Facilities walkaround scheduled for the coming weeks with aim for completion 31/01/2025. Schedule of works to be identified with timeframe for completion. Timeframe for completion of outstanding works to be given to PIC.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • PIC has recently completed training with the Health and Safety Officer in relation to risk assessment and an integrated risk management approach across Horizons. • Current individual risk assessments are currently being reviewed with additional controls are to be reviewed to collate with current health care needs, psychological and social needs of the person we support. • Information will be passed on to staff through staff meetings and personal plans • All individual risk assessments will be reviewed and updated by 30/04/2025.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • PIC discussed fire safety concerns in staff meeting held on the 15/12/2024. Further spot checks and monitoring to happen on a regular basis to ensure practices are up to standard • Facilities walk around to be held before 31/01/2025. PIC to discuss issues with extension panel on bedroom door and if self-release mechanism can be put in place so that the door will close in the event of fire alarm activation to ensure effective fire containment measures.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • The resident was reviewed by Neurologist on 10/12/2024. Following the review, a comprehensive protocol was developed in relation to the administration of PRN epilepsy medication. • The PIC has ensured that all information is consistent across the residents' prescription records, PRN protocol and epilepsy risk assessment and management plan.

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: • Full review of all assessments and documentation of personal plans will be completed by 30/06/2025 • Personal plan review team will be created and supported by the PIC • Nursing health action plans are currently being reviewed and updated by all nursing staff within the Designated Centre and supported by PIC to complete same • Goal process tracker are now in place in PCPs for individuals to support keyworkers and people we support to assist them with achieving their individual goals • Goals for each individual are under review in conjunction with the person we support and keyworker • Horizons key worker policy has just been updated and staff will complete the associated training presentation. The key worker role now has a clearly defined responsibility in relation to updating personal plans for the PWS • New activities record has been developed and will be rolled out across all personal plans in January 2025. • Full review of all assessment and documentation of personal plans will be completed by 30/06/2025.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • All communal areas have been reviewed by PIC and personal information has been removed from white board • PIC has spoken to the individual and addressed the issue • Staff in CCN 15 will complete the Human Rights Training developed by Work Stream 3 of the QCIP (Person Centred Care and Support) and the team will complete the associated work book together to support each other to strengthen a rights based approach culture in CCN 15 • A Lean 5S event took place in House 3 in CCN 15 on the 10th of December, with a focus on notice boards and the staff office. This was done with a mandate to ensure that only information relevant to people supported to live in CCN15 will now be displayed in communal areas, and all staff related information will be displayed in the staff office or on staff noticeboards in less conspicuous places. In addition, a centralized folder was created to ensure that important documents and information are available and accessible to residents, but are not displayed in such a manner that would give the house an impersonal, clinical atmosphere. Staff will support those who cannot access it independently. The folder contains information on the following: 1. Complaints procedures in easy to read (ETR). 2. Safeguarding 3. ADMA information 4. Information on internal advocacy	

5. Information on independent advocacy
6. Consent ETR
7. Information on the Confidential Recipient

• It is intended that similar 5S events will take place in all houses in CCN15 by the 31.3.25

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	30/06/2025
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/12/2024
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	Substantially Compliant	Yellow	30/06/2025

	development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/06/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2025
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/06/2025
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	Substantially Compliant	Yellow	30/04/2025

	responding to emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2025
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	31/12/2024
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	31/01/2025
Regulation 31(3)(a)	The person in charge shall ensure that a	Not Compliant	Orange	31/01/2025

	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.			
Regulation 31(3)(d)	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 injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	31/01/2025
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 foot of a complaint	Substantially Compliant	Yellow	31/03/2025

	and whether or not the resident was satisfied.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30/06/2025
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	31/03/2025