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 17
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	26 November 2024
Centre ID:	OSV-0005518
Fieldwork ID:	MON-0043240

About the designated centre

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

Cork City North 17 is comprised of two bungalows which are connected by a link corridor and located in a residential area on the outskirts of Cork City. Each bungalow is comprised of three individual bedrooms, kitchen-dining area, sitting room and laundry room. There is also a large shared bathroom in each bungalow equipped to meet the needs of the residents with an additional separate toilet facility. An activity room is located in the circular shaped link corridor and an outdoor sensory garden area is located at the rear of one of the bungalows. The designated centre also has an office and staff facilities. The designated centre provides full-time residential services for six adults, both male and female with a severe or profound degree of intellectual disability and complex needs. Residents are supported by a staff team that comprises of both nursing and care staff day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 26 November 2024	09:45hrs to 16:30hrs	Elaine McKeown	Lead
Tuesday 26 November 2024	09:45hrs to 16:30hrs	Kerrie O'Halloran	Support

What residents told us and what inspectors observed

This was an unannounced focused inspection completed to monitor the provider's compliance with the regulations and to meet with residents who were in receipt of residential services the designated centre on the day of the inspection. This centre was registered as a designated centre in January 2017. The most recent renewal of the registration of this designated centre had occurred on 27 January 2023. This designated centre was last inspected in August 2022 by inspectors of social services on behalf of the Chief Inspector. The inspectors acknowledge the provider had made changes to the management structure since the previous inspection and there was evidence of oversight by local management within the designated centre. However, the findings of this inspection identified gaps in compliance with similar regulations to the August 2022 inspection, which included Regulation 15: Staffing, Regulation 16: Staff training and development and Regulation 28: Fire precautions

On arrival to the designated centre, the inspectors were met by members of the staff team which included the person in charge. The inspectors were informed that there were six residents in receipt of full time residential services in the designated centre at the time of the inspection. One resident had already left to attend their day service and the inspectors were introduced to the remaining five residents at times that best suited their routine during the morning.

One resident was being supported in a sitting room at the far end of the building by a staff member. The resident communicated without using words and the staff member explained on behalf of the resident that the quieter environment was a preferred location in the morning time. The resident was observed to smile at the staff member as they spoke about the preferred programmes the resident liked to watch on the television, one of which was observed to be playing at the time of meeting the inspectors. During the day the resident was met with on a number of occasions. This included after their return from a swimming session where a family member had joined them. Staff explained how the team ensured weekly sessions in a local swimming pool with the relative were facilitated, either hydrotherapy sessions or regular swimming. In the afternoon, the resident appeared to be smiling and was holding a preferred soft toy while sitting in their personalised wheelchair in the company of peers in one of the large communal areas.

Another resident was introduced to the inspectors while being supported by the activation staff member in one of the kitchen areas. They had plans to complete some art and crafts work. The resident was observed to become excited and more vocal when they met the inspectors as they were not expecting visitors at that time of the morning. Both inspectors noted that the noise levels had risen after this introduction but no adverse impact was observed to be experienced by any of the other residents who were in a number of other locations in the designated centre at the time. As the inspection progressed it was evident the staff team provided quiet spaces when needed for some residents but equally residents were supported to share communal spaces with their peers. For example, in the evening time the same

resident was observed to be sitting on a couch, engaging with a staff member while three other residents were also present, all of whom appeared to be relaxed within the group.

Inspectors noted a sign on one of the kitchens advising a resident was being supported to have their breakfast. A "protected meal time" sign was clearly visible and observed to be respected while in place. Inspectors met this resident later in the day as they relaxed in their comfort chair in a communal space, positioned so that the sun was shining on them. Staff explained how the resident enjoyed massage therapy and other sensory activities in the designated centre. The resident was both blind and deaf, however staff outlined how the resident had previously enjoyed being present during a choir recital. As part of the planning of meaningful activities for this resident, the person in charge spoke of an upcoming Christmas choir which the resident would be supported to attend and avail of other social activities such as having a meal in the hotel where the choir were to perform. The resident was also known to respond in a positive manner to animals. While dog therapy had been available previously in the designated centre, the inspectors were informed it was no longer available. The inspectors enquired if any alternative options/activities were considered. The inspectors were informed no alternative activities which would provide opportunities for the resident to spend time with animals were planned as part of the resident's goals at the time of this inspection.

An inspector was invited to visit a resident in their bedroom after they had completed their morning routine. Staff had ensured the resident who required increased supports with all of their activities of daily living was able to look out of their bedroom into the hallway to see the activity and what was going on in the designated centre. The inspector was introduced by a staff member and it was evident that the staff member understood what the resident was communicating to them in their responses. This included a nod of the head and smiles. The person in charge explained that a new wheelchair had been ordered for the resident to improve the support provided due to changes in the resident's posture and medical condition. It was hoped the resident would be more comfortable in their new chair as currently they were finding it difficult to spend more than an hour in their current wheelchair. The inspector was informed the resident had previously attended a day service each weekday and it was hoped they could return once their new wheelchair arrived and they were able to spend longer periods of time in a comfortable seated position.

Both inspectors met this resident again in the early afternoon as the resident listened to music in the communal area and watched a staff member prepare seasonal crafts. It was evident staff ensured the ongoing comfort of the resident such as moving them when the sun was observed to be shining directly into their eyes and ensuring the resident could see what craft work was being done. Staff were also engaging in meaningful conversation with the resident during this time, outlining their likes and preferences. The resident was observed to smile and acknowledge the staff member.

It was evident staff spoken to during the inspection were familiar with the residents, their preferred routines and preferences. Staff demonstrated how they ensured

individualised personal care was provided to each of the residents. This included flexibility in supporting residents to attend medical appointments. For example, one resident was being supported to attend a consultant appointment which was arranged to take place at the end of the consultant's planned clinic at a time the resident would not be waiting an extended period of time to be seen and there would be reduced noise and activity in the clinic. A staff member was rostered on duty in the evening to support the resident to attend this appointment. The inspectors were introduced to this resident at the end of the inspection as they had been attending their day service. The staff spoke of how the resident enjoyed being out in the community and plans for attending seasonal events such as a winter wonderland light show with peers which had been booked and would be taking place before Christmas.

Inspectors were also shown a template which was planned to be used to establish the will and preference of the residents in making decisions in their lives. The preferred activity analysis contained 30 questions and was specifically designed to be a supportive decision making tool for people who communicate informally. The staff team outlined how the individual responses once collated would also be used to enhance the meaningfulness of the residents forums during 2025.

Staff also outlined to the inspectors the difficulties that had been encountered during periods of reduced staffing resources in the designated centre on occasions since the previous inspection. While the safety of residents was of paramount importance to the team, the ability to provide meaningful activities in the community had been adversely impacted at times. Staff spoke of the complex assessed needs of the residents, the changing presentations of medical conditions and the ongoing supports required by the residents with all activities of daily living. Some staff members had worked additional hours to ensure familiar staff were providing support to the residents. A complaint had been made by staff members in August 2022 on behalf of the residents due to the adverse impact of the staffing resources at that time. The provider had responded, staffing vacancies were filled and the satisfaction of the complainant was documented. However, the inspectors were informed that the person in charge had recently escalated the risk of staffing resources to senior management which included the inability to release staff to attend training. This will be further discussed in the capacity and capability section of this report.

The designated centre was warm, welcoming and reflective of personal interests and preferences of each of the residents. While the bedroom spaces were limited, each resident had an over head hoist to support their assessed needs and furniture arranged to best meet the assessed needs of each resident with the space available. This included the positioning of beds in each bedroom. There was evidence of regular cleaning taking place and this included protocols for cleaning specific medical equipment required by one resident. These were observed to be completed to a high standard. However, there were signs of general wear and tear on internal walls with previously planned internal painting postponed to January 2025. In addition, storage facilities within the designated centre required further review. It was observed in one bathroom that numerous boxes, including care products were stored on the floor. One sitting room had an electric floor cleaning machine stored

next to the couch. Some electrical items that had notes on them to say they were broken were being stored in another communal area. The inspectors acknowledge the person in charge had identified the issue regarding adequate storage facilities within the designated centre in advance of this inspection. In addition, effective fire containment measures were observed not being consistently maintained during the inspection with an extension panel on a fire door in an opened back position and another fire door not fully closing when reviewed by an inspector during the walk about of the designated centre.

In summary, residents appeared to be happy and content in the company of familiar staff during the inspection. The atmosphere was relaxed and homely. Staff were observed to consider individual preferences and interests of each resident when planning activities during the inspection. At the time of this inspection not all staff had completed training in human rights but this was in progress. Residents were being supported to maintain links with family members including video calls, sending photographs and visits. Progress had been made to ensure residents were being supported to have access to their finances. However, the current staffing resources were described as being stretched in the months prior to this inspection and remained the situation at the time of the inspection. This also had a direct impact on staff members being able to complete scheduled reviews of personal plans and other documentation within the required time lines. On review of such documents by both inspectors during the inspection, not all of the information was found to be up-to-date and relevant to the current situation for some residents.

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, the findings of this inspection identified some issues pertaining to how the designated centre had been impacted in the provision of services since the previous inspection in August 2022. The inspectors acknowledge the provider had made some progress implementing systems for monitoring and oversight and there had been a new person in charge appointed to the designated in recent months after the role became vacant.

The remit of the person in charge was over three designated centres at the time of this inspection. This person worked full time and demonstrated the progress and effectiveness of reviews that had taken place since they took up the role in September 2024. However, due to ongoing challenges relating to staffing resources the person in charge had worked on the front line to support the staff teams. In total they had worked 20 days to fill gaps in staffing levels since taking up the position which had directly impacted on their ability to attend to some of the

regulatory responsibilities of their role including the supervision of staff in this designated centre.

On the morning of the inspection, the person in charge had scheduled meetings that required their attendance. The senior staff working in the designated centre on the day assisted with providing information and all documentation that was requested by the inspectors for review during the period of time the person in charge was not present. The inspectors spoke with eight staff during the day which included nurses, care assistants, two students on placement, the person in charge and the person participating in management. This also included an activation nurse who was on duty for five hours during the inspection. This role was scheduled to provide dedicated activation to the residents in the designated centre four days each week for five hours each day.

One of the challenges faced by the staff team due to circumstances that had arisen, was that a dedicated staff member to provide assistance with activation activities was unavailable for an extended period of time. This included at least six consecutive weeks during September and October 2024. This resulted in core staff team members trying to support residents with the activities of daily living (ADLs) while also trying to engage the residents in meaningful activities. In addition, staff were also unable to attend for mandatory training due to the ongoing challenges of the staffing resources within the designated centre. The current issue regarding staffing resources and the demands on the core staff team had been escalated by the person in charge on 21 November 2024 to senior management.

The inspectors were informed that staff members who were employed on a less than full time basis did assist with filling gaps and worked extra hours where possible to help maintain the service provision within the designated centre. While minimal staffing levels had been maintained in line with the statement of purpose, the frequency of such instances had increased. Actual and planned rotas from the 23 September 2024 until 15 December 2024 were reviewed by an inspector. This was 11 weeks in total. The reason for the review of such an extended period of time was a result of the frequency of minimal staffing levels in the designated centre. For example, on 23 September 2024, the person in charge had to work on the front line and change their planned shift to a full day shift to provide minimal staffing levels and skill mix within the designated centre. On the same date a staff member who had a job sharing contract worked extra hours from 08:00 hrs until 17:00 hrs. Actual rotas reviewed during this period also reflected the absence of the activation staff member.

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. However, the annual review for 2023 was not completed until May 2024. This had been identified as an action during the provider's internal audit of 19 February 2024. No other internal six monthly audit had been completed by the provider since 19 February 2024. The inspectors were informed by the person participating in management that such an audit was scheduled to take place however, in line with regulatory requirements this should have been completed in August 2024.

During the inspection, the inspectors were provided with an update on the outcome of an external investigation which was carried out following a complaint being made in November 2022 about the service provision within the designated centre for a named resident. The findings of the investigation outlined the supports and actions taken by the staff team and allied health care professionals during a challenging time for the resident who was being supported by the provider with a respite break due to changed circumstances in the family home. The findings of the investigation outlined there were no recommendations to be made to the provider as it was found all staff had worked within their scope of practice.

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed to the designated centre and that they held the necessary skills and qualifications to carry out their role. They worked full time and their remit was over a total of three designated centres at the time of this inspection.

- The person in charge was aware of their role and responsibilities, including their legal remit with regards to the regulations.
- The person in charge was found to be competent.
- Throughout the inspection they demonstrated their ability to effectively manage the designated centre. They were able to demonstrate the oversight and review of services being provided in the designated centre since they took up the role in September 2024 while ensuring the voice of the resident was listened to.
- The person in charge had implemented additional weekly checks within the designated centre which included ongoing review of medication management practices,. For example, ensuring all open bottles containing liquid medication had being correctly labelled
- The person in charge had escalated their concerns regarding this designated centre to senior management prior to this inspection, in relation to the minimal staffing levels and the changing assessed needs of residents in the designated centre. .
- On review of documentation during the inspection including staff meeting notes, internal audits and resident forums, the person in charge consistently communicated effectively with all parties including, residents and their family representatives, the staff team and management.
- They were supported in their role in this designated centre by a small group of consistent core staff. Some duties were delegated among team members with oversight by the person in charge including, scheduled audits. The person in charge outlined to the inspectors plans to further delegate duties among the staff team which included reviews of personal plans and personal goals.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had identified the skill mix and number of staff to provide services and meet the assessed needs of the residents living in the designated centre. This was reflected in the current statement of purpose of the designated centre. However, due to ongoing challenges experienced with staffing resources, the minimal staffing levels were frequently all that was available to support the residents which directly impacted on the ability of the staff to assist with residents to engage in meaningful activities due to prioritisations of supporting the residents with their ADLs, some of whom had complex medical needs and required full time nursing staff support. For example, on the day of the inspection one of the residents required immediate attention to support a known medical condition. The resident was effectively supported by the staff on duty and the resulting nursing care and observations that were required were being provided to the resident. This demonstrated how staff had to continually re-evaluate the provision of the care and support being provided during each day to each of the residents in this designated centre.

- The staff team consistently demonstrated their commitment to providing a safe and quality service by ensuring familiar staff were on duty when challenges with staffing resources arose. This included staff who did not work full time regularly undertaking additional hours to support the residents. The inspectors were informed during the inspection this was not sustainable in the long term and had been escalated to the provider's senior management team. This will be actioned under Regulation 23: Governance and management.
- The person in charge had ensured an actual and planned rota was in place which reflected staffing levels on all shifts. However, the actual hours that staff worked during regular shifts were not documented. For example, the start and end time of the night shift were not clearly documented, an abbreviation was used.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspectors acknowledge difficulties had been experienced by the person in charge in recent months to release staff to complete/attend mandatory and other training requirements to ensure all staff had up-to-date knowledge to support the assessed needs of the residents in the designated centre.

The person in charge had reviewed the training requirements of the staff team on 20 November 2024. However, of the 20 staff who were included in the training

matrix in the designated centre at the time of this inspection a number of gaps were identified. These included-;

- 55% of staff did not have up-to-date training in safeguarding
- 85% of staff did not have up-to-date training in infection prevention and control, which was deemed to be necessary to support the complex needs of some of the residents in receipt of services in the designated centre.
- 80% of staff did not have up-to-date training in fire safety. This issue will be actioned under Regulation 28: Fire precautions.
- Not all staff had up-to-date manual handling training which was identified as necessary during the minimal staffing fire drill in June 2024. Two staff required this training at the time of the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The inspectors were aware the provider had implemented changes within the organisation to enhance oversight and governance during 2024. This included an audit system which was monitored by senior management and was noted by inspectors to be in place in this designated centre since March 2024.

While the provider had identified the resources and skill mix of staff required to support the assessed needs of the residents in this designated centre and maintained minimal staffing resources in line with the statement of purpose, the provider had not ensured effective arrangements were consistently in place to assist and support staff with the delivery of care being provided in the designated centre.

- The provider had not ensured an annual review of the services provided in the designated centre for 2023 had been completed in line with the provider's own procedures until May 2024.
- An internal six monthly audit had not taken place in the designated centre since February 2024, The inspectors acknowledge progress updates on the actions identified in that audit were documented and provided on the day of the inspection.
- Effective arrangements were not in place for staff to attend mandatory and additional training deemed necessary to meet the assessed needs of the residents such as manual handling.
- The performance management of staff during 2024 had not taken place or commenced at the time of this inspection. This was not in line with the provider's own policy and procedures of the annual performance management for the staff team.
- The ongoing challenges of staffing resources experienced within this designated centre directly impacted the ability of local management systems in this designated centre to ensure consistent service provision appropriate to

residents assessed needs and effective monitoring was maintained.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had ensured the statement of purpose for the designated centre had been subject to recent review in September 2024 to reflect the most recent changes to local management. All of the required information as outlined in the regulation was found to be present and reflective of services being provided, including minimal staffing levels.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that written notifications as outlined in the regulation were being submitted to the Chief Inspector within the time lines.

- These included the submission of quarterly notifications.
- On review of the documented incidents within the designated centre since 9 July 2024 by one inspector, they were assured the Chief Inspector had been informed of adverse incidents as required by the regulations

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had not insured written notification had been submitted to the Chief Inspector within 28 days of the absence of the person in charge. The previous person to hold the role had ceased to be in the role on 19 July 2024. This was a planned departure. A notification was submitted to the Chief Inspector on 22 August 2024, 42 days after the person in charge had departed their role. The provider notified the Chief Inspector in the same late notification that a new person in charge would be taking up the role on 16 September 2024. This was 69 days after the departure of the previous person in charge

Judgment: Not compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

As the provider had not ensured written notice had been submitted to the Chief Inspector as required under Regulation 32: Notification of periods when the person in charge is absent, this also resulted in the provider not giving written notice to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the said absence. The inspectors acknowledge the statement of purpose does outline the local arrangements to be in place in the event of the person in charge being absent. However, the provider had not ensured the regulatory requirements had also been met during this period of absence.

Judgment: Not compliant

Regulation 34: Complaints procedure

- The provider updated the organisation's complaints policy in December 2023 and this was circulated to the staff team.
- Residents and their family representatives were provided with accessible information regarding complaints.
- Staff had documented a complaint in August 2022 on behalf of the residents living in the designated centre regarding staffing resources and the adverse impact to the services being provided. The provider responded and the vacancies were filled. The satisfaction of the complainants was documented.
- No further complaints or comments were documented in the complaints log reviewed by one inspector since the previous inspection.
- The inspectors acknowledge no recommendations or actions on the part of the provider were reported to be required/deemed necessary following an external investigation that had been conducted following a complaint made to another state agency regarding the provision of services in this designated centre during a specific period.

Judgment: Compliant

Quality and safety

There was evidence the provider had sought to make changes within the organisation to enhance the quality of services being provided. The inspectors acknowledge there was evidence of increased oversight and of improvements in progress in recent months to ensure a quality service was being provided to all residents. The provider had demonstrated actions had been taken to attain

compliance with a number of regulations including residents rights. However, due to ongoing challenges regarding staff resources this had an impact on residents attaining or progressing with their personal goals.

At the time of this inspection only two residents did not attend a day service regularly. The rationale for this was provided to the inspectors. One resident's individual assessed needs identified they preferred their routine and activities to be based within the designated centre. The other was due to a change in their medical needs and there were plans to assist the resident to return. However, on review of this resident's personal plan the current services being provided was not updated or reflective of their assessed needs which had changed in the months prior to this inspection taking place.

The remaining four residents were supported to attend their day services regularly. However, not all had returned to the same level of attendance as they had prior to the pandemic in March 2020. This was due to staffing resources within the provider's day service which still had an impact on the level of services being available. Two of these residents attended on alternate days to ensure equity. However, due to other challenges within the designated centre, a dedicated activation staff was not available to provide additional support to the residents in the designated centre. This role provided for 20 hours dedicated activation each week. It was evident that when this additional resource was in place it benefited the residents to avail of increased opportunities such as craft work or socialising such as seen on the day of the inspection.

The evidence to demonstrate residents were being supported to attain both long and short term goals was not consistently documented. There was at times no progress or updates documented. For example, one resident was to go on a holiday during 2023. However, the only entries pertaining to that resident attaining goals were relating to a shopping trip in January 2023 and a trip to Funderland in April 2023. There were no further updates or entries for 2023. The only entry for 2024 for the same resident was in March 2024 where they were having a takeaway at weekends which was a short term goal from 2023. This resident also had a long term goal to go on a train, no details of any steps or progress being made to attain this goal were documented. Another resident's personal plan contained evidence of their participation in social outings and goal attainment during 2021, 2022, and 2023. However, there was no evidence of any activities or goals being attained by the resident during 2024 in their personal plan.

There were gaps evident in some other documentation that was reviewed during the inspection. This included reviews of personal plans in line with the provider's own guidelines, hospital passports and individual risk assessments. The inspectors acknowledge that the person in charge had scheduled the review of two residents personal plans with family representatives for December 2024. However, another resident's personal plan did not contain a copy of the most recent review of the person centred planning meeting. The last review available for inspectors on the day of the inspection was dated to have taken place in 2022.

Regulation 10: Communication

Residents personal plans had identified their communication needs. Resident's communication passports had been recently reviewed in November 2024, which contained relevant information regarding specific communication needs including the use of objects of reference. Residents were supported to maintain regular contact with relatives in pre -arranged formats such as photographs or video calls.

Judgment: Compliant

Regulation 13: General welfare and development

The inspectors acknowledge the registered provider was aware there were gaps in the restoration of day services to residents in this designated centre to the same frequency as they had been availing of prior to the pandemic in March 2020. In July 2024 during one resident's person centred planning meeting it was highlighted that the resident did miss the opportunities to participate in activities as they had previously with peers.

Four residents were being supported to attend day services regularly each week. Staff outlined plans to support one resident to return to their day service once a new wheel chair had been delivered which it was hoped would assist the resident to be more comfortable in a seated position. It was evident staff in the designated centre endeavoured to assist with providing meaningful activities within the designated centre as often as possible, such as hand and foot massages, baking and art activities. Music activities were also part of daily engagement with the residents.

However, opportunities within the designated centre for residents to participate in activities in accordance with their interests, capacities and developmental needs had been adversely impacted due to the absence of a dedicated activation staff in the designated centre in recent months. The reduced availability of this resource limited the opportunities available to the residents while remaining in the designated centre. The role was described in the current statement of purpose as being 0.5 whole time equivalent role.

Judgment: Substantially compliant

Regulation 17: Premises

The premises was reflective of being a home to the residents living in this

designated centre, with personalised bedrooms and decor demonstrating preferences of each individual. The inspectors acknowledge that internal painting had been identified as being required but had been postponed by the provider until January 2025.

However, the current layout and design required boxes of excess products to be stored on the floor and in a bathroom. This was observed on the day of the inspection. In addition, the storage of electrical floor cleaning equipment in a sitting room when not in use also required review.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The person in charge had ensured that where residents required assistance with eating and drinking including percuateous feeding regimes, a sufficient number of trained staff were on duty at all times. Staff were found to be knowledgeable in the particular requirements of each resident. They spoke of recent changes being made to protocols and there was documented evidence of review by the speech and language therapist and dietician as required .

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had ensured there was a risk management policy in place which had been subject to regular review. Within the policy guidelines the frequency of the review of risks were outlined. In addition, a centre specific review of risks with time lines for review was also in place in each residents personal plan. If there were no changes in assessed needs or circumstances of residents, their individual risks were to be documented as requiring review either six monthly or annually. Where a risk was identified as a medium/orange risk a review within six months was required to be completed.

However, following a review of individual risk assessments for three of the residents during the inspection, gaps were evident in the review process. For example, one resident had a risk assessment pertaining to accidental injury in place due to their unsteady gait. This was reviewed in July 2024 with controls to reduce the risk documented. However, the same resident had a further review in September 2024 by the multi-disciplinary team and the risk was not updated to reflect the most recent control measures in place. Another resident had been identified as being at medium risk of aspiration, while this had been reviewed on 8 Septmeber 2024 this was not within the six month period of the previous review date. A review of

another medium risk for a resident relating to the management of a known condition had been reviewed in April 2024 and no six monthly review had taken place at the time of this inspection.

As part of the systems to review risks the provider had procedures which included the requirement for the next scheduled review dates to be documented. This was not consistently documented for some risks within the designated centre. It was unclear to inspectors when the next scheduled reviews were required to be completed for some risks within the designated centre. For example, one resident's individual risk assessment pertaining to their safety had been reviewed in January 2023, April 2023, March 2024 and July 2024 but no details documented of the next planned date of review.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had not ensured that fire safety systems were in place. During the inspection and following a review of documentation relating to fire safety the following issues were identified-;

- On the day of the inspection, a fire door was observed not to be closing effectively. This was demonstrated to the person in charge and person participating in management at the end of the inspection.
- Not all extension panels to fire doors were observed to be in the closed position during the walk through of the premises by inspectors which adversely impacted the effectiveness of fire containment measures within the designated centre.
- On review of a selection of daily fire safety checks, all had been completed and documented since 22 October 2024. However, weekly fire checks had not been consistently carried out with extensive gaps evident in the records reviewed. For example, there were no documented checks between 18 March 2024 and 10 June 2024, or between 26 June 2024 and 5 August 2024.
- Two residents who had specific medical needs documented in their health care plans and were assessed as requiring to have access to emergency medication at all times did not have this requirement considered in their PEEP. This was discussed during the feedback meeting at the end of the inspection.
- While regular fire drills had taken place in the designated centre including minimal staffing levels, the actual evacuation time for such a drill on 28 September 2024 was four minutes and the previous minimal staffing drill on 17 June 2024 was three minutes 30 seconds. These time lines were exceeding the three minute evacuation time as per the guidance documented on the provider's fire drill form that was completed by the staff team.

- Only four staff had up-to-date training in fire safety at the time of this inspection, the training for two of these staff was noted to be out of date within two weeks of the date of this inspection.
- Not all staff had up-to-date manual handling training which was identified as necessary during the minimal staffing fire drill in June 2024. Two staff required this training at the time of the inspection.

Judgment: Not 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. However, not all of these plans had been subject to a review within the previous 12 months or when circumstances had changed.

During the inspection, the personal plans of three residents were reviewed by inspectors. Some areas were identified which needed improvement from the personal plans reviewed, such as:

- One resident's documentation referred to them attending their day service four days each week. This was not reflective of the services being provided due to a change in the resident's assessed needs.
- One resident did not have a documented review of their person centred planning since 2022
- The irregular completion of personal goal logs did not provide evidence of residents being supported to attain or make progress to attain personal goals. This included a resident not being supported to prepare and engage in steps to attain a goal of going on a holiday, or another resident was to be supported to visit a train station with a goal to travelling on the train. There was no documented evidence of any activities or progress being made to attain this goal for the resident.
- The review time lines in line with the provider's schedule for review for different sections of residents personal plans lacked updating or evidence of review taking place as required. This included annual health checks not being fully completed. For example, one resident's health check assessment dated 8 November 2024 had only 52 out of 133 questions competed. An individual risk assessment for one resident relating to the management of a medical condition was reviewed on 8 April 2024 and documented as requiring review within six months, this review was overdue at the time of this inspection

Judgment: Not compliant

Regulation 8: Protection

The person in charge had ensured safeguarding measures were in place to ensure all residents had up-to-date information contained within their intimate care plans to ensure their privacy and dignity was respected. These plans were found to be reflective of each resident's individual assessed needs and subject to recent review.

However, not all staff had been supported to attend refresher training as required in safeguarding, this will be actioned under Regulation 16: Staff training and development.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had ensured each resident's privacy and dignity was being respected. This included all six residents having bank accounts in their own names. The person in charge outlined the arrangements in place for one resident regarding accessing their finances and this was under further review at the time of this inspection.

- Staff demonstrated on going review of services being provided to residents, including developing more meaningful residents forums being planned for 2025.
- Staff demonstrated their focus on providing a good quality of life to each resident, taking into account each residents individual preferences and assessed needs.
- Staff demonstrated their ongoing efforts to ensure residents were supported to meet and engage with family members in planned activities such as swimming.
- Residents were being supported to attend activities in the community and engage with their local communities such as going on walks to local shops and other amenities located close by the designated centre.
- Residents also has access to transport which assisted the staff team to provide other social outings regularly.

Judgment: 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cork City North 17 OSV-0005518

Inspection ID: MON-0043240

Date of inspection: 26/11/2024

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: • The PIC will ensure planned and actual staff rotas reflect actual hours worked including start and end times of duty The provider has outlned actions with regards to staffing resources under Reg 23 response.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC or delegate will conduct a monthly review of the designated centres training matrix. Monthly review will be commencing from January 2025 • The PIC will allocate protected time going forward for staff to complete mandatory online training. Staff will ensure all training will be agreed and scheduled with the PIC with Dates and times documented on the rota. • Safeguarding will be completed by 3 staff by 24/01/2025 • Infection, prevention and control will be completed by 11 staff. To be completed by 01/02/2025. • Fire training requested for staff and will be completed by 1/2/2025. • Manual handling training for 1 Staff will be scheduled offsite on 12/2/2025.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PIC and PPIM will conduct a staffing resource audit and update staffing map if required for the designated centre.
• PIC and PPIM will submit Approval to Hire (ATH) forms for 2 identified vacancies following staffing resource audit and updating of staffing map for designated centre.
• Provider to review ATH request form at monthly allocations/ATH forum meeting.
• A full-time care staff was priortised through the recruitment process on 25.11.24. One relief care staff commenced on 24/11/2024. Currently there is two care assistant vacancy in CCN17. CNM 1 is due back from Statutory leave in Feb 2025. This will enable the PIC to focus more on local management systems and increase governance and management of the service.
• The PIC and PPIM will continue to review staffing resources in CCN17 as part of their monthly 1:1 governance meeting. Escalations will be made as required through the agreed pathways.
• Annual review will be completed by 31.05. 2025.
• The Provider has appointed an internal auditor to complete Reg. 23 six-monthly audits. The provider will ensure audits are completed in line with regulatory requirements and timelines.
• A schedule of performance management has been completed by the PIC. All staff will participate in performance management which will be completed by 31/03/2025.

Regulation 32: Notification of periods when the person in charge is absent	Not Compliant

Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent:
• Going forward, the provider is confident there are systems and processes in place which will ensure that notification is submitted to the Chief Inspector in accordance with the timeframe outlined in the regulations 10.01.2025
• PIC in place in designated centre since 16/09/2024.

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is	Not Compliant

absent	

Outline how you are going to come into compliance with Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent:
• Going forward the provider will submit in writing interim arrangements which are put in place in the absence of a PIC to ensure governance and management of the designated centre into the future. 10.01.2025

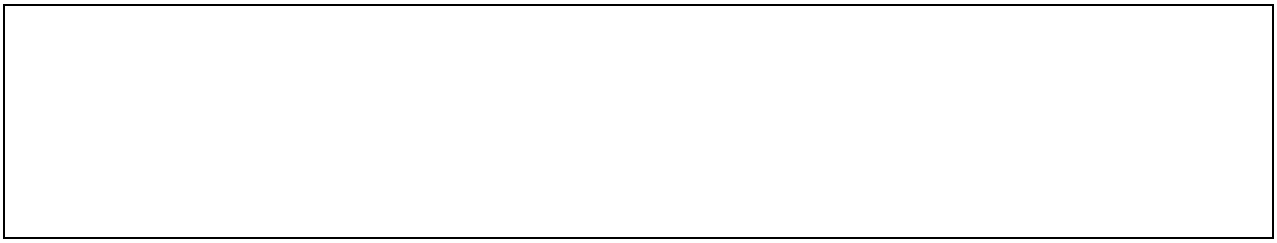
Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• The PIC will meet with the Day Service Manager in January 2025.
• In line with the residents will and preference, the PIC and Day Service Manager (or delegates) will support the residents to avail of their allocated day service and a plan will be developed to support the resident to access activities in line with their PCP Goals. The team will commence this work in January 2025.
• All resident's PCP's will be reviewed and completed by 28/02/2025.
• The activation staff will support the staff team to maintain a timetable with a detailed log of activities capturing individual's participation in activities in accordance with their interests, capabilities and developmental needs. To be updated daily. To be completed by 15.02.2024.
• If residents choose not to attend day services, it will be documented in the resident's personal plan.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Additional storage has been sought through the Facilities Department
• A garden shed to be installed by 31/03/2025.
• Additional storage throughout the centre to be fitted by carpentary . To be completed by 31/1/2025.
• The current space within the designated centre has been reviewed to ensure electrical equipment is stored correctly. Completed on 23/12/2024.
• Painting of CCN17 is due to commence on the 20/01/2025.

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • All individual risks will be reviewed by the 31/03/2025. A schedule will be completed to ensure the risk management procedure are carried out as per the organisations policy.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Fire doors have been reviewed by an independent external contractor. Maintenance on fire doors will commence on the 3/02/2025. To be completed by the 1/03/2025. • Weekly fire checks are now scheduled in 2025 diary. A Designated fire officer will be assigned daily by senior staff nurse on duty. Fire equipment will be reviewed annually next review scheduled for 6.06.2025 . • Emergency medication is now kept in the designated center across from CCN17 in case of an emergency. This will be reviewed/checked every 6 months to ensure its within date. • Please see regulation 16 response for action regarding fire training. • CCN17 designated center meeting occurred on 3/1/2025 where fire drills and fire checks were discussed. A scheduled fire evacuation will take place on the 24/1/2025. PEEP's will be updated following this to be in line with the most recent evacuation.	
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: • All personal plans will be reviewed in line with Horizons Personal Plan format. Staff on night duty will take a lead role with healthcare plans and submit updates to PIC weekly • All health care assessments will be reviewed and updated by staff nurses and management by 31/03/2025. • Personal Goals will be documented in a stepped approach. PIC and PPIM have scheduled a plan of documentation to be completed by 31/03/2025. Staff will be commencing PCP training in February 2025.	



Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/03/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	01/01/2025
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	Not Compliant	Orange	12/02/2025

	professional development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/03/2025
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	31/05/2025
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	31/05/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated	Not Compliant	Orange	31/05/2025

	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.			
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.	Not Compliant	Orange	31/05/2025
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 responding to	Substantially Compliant	Yellow	31/03/2025

	emergencies.			
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	06/06/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/03/2025
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Orange	01/02/2025
Regulation 32(1)	Where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more, the registered provider shall give notice in writing to the chief inspector of the proposed absence.	Not Compliant	Orange	10/01/2025
Regulation 33(2)(a)	The notice referred to in paragraph (1)	Not Compliant	Orange	10/01/2025

	shall specify the arrangements which have been or were made for the running of the designated centre during the absence of the person in charge.			
Regulation 33(2)(b)	The notice referred to in paragraph (1) shall specify the arrangements that have been. are proposed to be, made for appointing another person in charge to manage the designated centre during that absence, including the proposed date by which the appointment is to be made.	Not Compliant	Orange	10/01/2025
Regulation 33(2)(c)	The notice referred to in paragraph (1) shall specify the name, contact details and qualifications of the person who was or will be responsible for the designated centre during the absence.	Not Compliant	Orange	10/01/2025
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	Not Compliant	Orange	31/03/2025

	out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
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	31/03/2025