Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	East County Cork 2
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	02 October 2024
Centre ID:	OSV-0003290
Fieldwork ID:	MON-0044554

About the designated centre

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

This is an adult short break / respite service for people in receipt of full-time day services operated by the same provider. Residents availing of short breaks have a diagnosis of an intellectual disability and / or autism. The designated centre can accommodate up to six adult residents at any one time, both male and female. The premises is located in a large coastal town adjacent to facilities and amenities. The premises comprises two semi-detached houses over two floors, which presents as one large house. There is a kitchen / dining room and two living room spaces. There are five bedrooms upstairs, and one wheelchair-accessible bedroom downstairs. Toilet and bathroom facilities are located on both floors. There is also a staff office on the ground floor. There is a secure garden space to the rear of the property and parking for transport vehicles at the front. The residents are supported by a staff team both by day and waking staff at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 2 October 2024	08:30hrs to 17:00hrs	Elaine McKeown	Lead

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 availing of respite breaks in the designated centre on the day of the inspection. This centre was registered as a designated centre in 2016. During the current registration cycle the centre was inspected in January 2023, December 2021 and January 2020 by inspectors of social services on behalf of the Chief Inspector. The findings of these inspections had found issues in relation to similar regulations including Regulation 23:Governance and management, Regulation 29: Medicines and pharmaceuticals, Regulation 16: Staff training and development and Regulation 5: Personal plans. The provider had been requested to submit a compliance plan update in August 2024. This inspection was undertaken to follow up on the actions outlined by the provider to the Chief Inspector in the compliance plan update submitted in August 2024.

On arrival at the designated centre the inspector's identification was reviewed by a staff member. The inspector was asked to wait outside the building while staff explained to the residents who the unexpected visitor was and the purpose of their visit. The inspector was introduced to the two residents in the hallway as they were ready to depart to their day service. There were two waking night staff who had finished their shift also getting ready to leave the building at the same time.

One resident was observed to be supported by staff to put on their coat and gather their belongings before leaving the designated centre. Staff explained that the resident had completed their short break and would be going home to their family in the evening after attending their day service. The other resident returned to the designated centre later in the afternoon before the inspector finished the inspection.

Due to unforeseen circumstances one resident who was scheduled to attend for a short break on the evening of the inspection was unable to avail of the service. In addition, during the day, staff on duty were informed another resident was going to be arriving later in the evening as they were with a relative who would bring them to the designated centre. The inspector did meet with another two residents in the late afternoon when they arrived at the designated centre to begin their planned short break.

The inspector met with a total of four residents during the inspection. There was only a brief period to engage with the two residents in the morning. It was evident staff were familiar with the preferences and routines for both of these residents. For example, one resident did not like to step off the foot path outside the designated centre and the staff member was observed to walk with the resident to a gentle sloped section which the resident preferred before they got to the transport vehicle.

The second resident was ready to leave the designated centre and did not engage very much with the inspector. However, staff explained the preferences and routines

that the resident liked to follow when in the designated centre. This included having an item available to them in their hand as a sensory stimulus. In addition, staff explained a specific routine that was required to support this resident with their meals and nutritional intake.

The inspector was introduced to two other residents at the end of the inspection on their arrival to the centre after attending their day service. The third resident who the inspector had met earlier in the morning did not want to enter the building when there were people in the hallway. The person participating in management suggested that the group go into the kitchen to allow space for the third resident to enter the building. The inspector received a hug from one resident and a warm welcoming handshake from the other. Both told the inspector they were very happy to be staying in the designated centre for their short break.

Both residents engaged in jovial conversations with the staff and the inspector while all were seated at the kitchen table. The residents spoke about holidays and travel plans for the coming months. They explained how they liked coming to spend time in the designated centre. They spoke about their day service. What bedroom each of them would be sleeping in and what they would like to have for their evening meal. The staff supporting them was observed to outline what evening activities could be facilitated including going shopping for the ingredients for their preferred evening meal. It was evident the residents were familiar with the staff supporting them, calling them by name and referencing what activities they enjoyed on their last short break, which included walks to local amenity areas.

The inspector was informed that at the time of this inspection 45 residents were regularly availing of respite breaks in the designated centre. The person in charge and the short breaks co-ordinator worked together to schedule planned respite breaks. This planning included reviewing the common interests, similar ages and individual assessed needs of each resident. In addition, the compatibility of the group was also part of the planning process. The staff team outlined the process involved if a resident was unwell or unable to attend. This was observed on the day of the inspection. One resident was unable to attend due to illness and the senior staff on duty in the designated centre informed the short break co-ordinator. The inspector was informed this was done to provide an opportunity for another resident to avail of the service where possible. The inspector was informed one of the residents who the inspector had met in the morning had been offered a short break for the previous two nights when another resident was ill and could not attend.

There was evidence of upgrade works taking place at the time of the inspection. Carpets had been removed and new flooring in place. Fire doors had been replaced and new door frames installed. The ceilings had been painted and further painting of the walls was scheduled to be completed in the weeks after this inspection. The provider had advised in August 2024 in the updated compliance plan that they expected these works to be completed by the end of September 2024. The inspector reviewed records of recent maintenance issues identified by staff in the designated centre and these were documented as being addressed in a timely manner by relevant personnel. However, the external area to the rear of the building had been identified as requiring immediate attention during a review of the annual report

action plan by the person participating in management and the person in charge in July 2024. This was documented as being required to improve access to the area and ensure the safety of residents using the space. It was not evident on the day of the inspection that these issues had been adequately addressed. The space was viewed to be empty of furniture, overgrown with weeds in places and did not appear to be in regular use.

The person in charge was unavailable on the day of the inspection. The inspector completed a walk around of communal areas with the person participating in management. They explained the progress made to date on upgrade works within the designated centre. There was evidence during the inspection of the pre-planning required by the staff team to prepare for the residents scheduled to attend later in the evening. This included staff on duty linking with residents day services, reviewing relevant personal plans and documentation. The staff explained these duties would usually be completed with the assistance of the person in charge. In addition, the two staff on duty during the inspection had driven two residents to their respective days services in the morning. They also had to ensure each bedroom was prepared in advance for the residents arrival later in the day. In the afternoon they had to ensure they were on-time to collect the three residents from their respective day services. The inspector noted that one day service had contacted the staff in the designated centre explaining they needed one of the residents to be collected by a particular time due to staffing issues in that day service. The inspector observed both staff to be very busy throughout the day. However, all interactions observed between the staff team and the residents were respectful and professional in nature.

On the day of the inspection some issues were identified which were reflective of not all processes being completed in line with the provider's protocols and in some instances not in line with regulatory requirements. For example, not all open food items were labelled with the date of opening in the refrigerator. Not all incident forms had been completed correctly or in full by members of the staff team. Infection prevention and control measures were not consistently completed or documented. Ongoing governance and management in the designated required further review to ensure issues identified were being adequately addressed in a timely manner. This included the structured supervision of the staff team.

Following a review of documentation, the inspector became aware during the inspection that controlled prescription medications had been present in the designated centre. The inspector found evidence that these medications were not stored, accounted for, recorded or administered on at least three occasions during August 2024 in line with the provider's medication policy or the Misuse of Drugs Regulations 1988, as amended. There were no controlled drugs on the premises at the time the inspector became aware of the issue. These findings were discussed with the person participating in management on the day of the inspection and with the provider's Chief Operations Officer the day after this inspection. This will be further discussed under Regulation 29 : Medicines and pharmaceuticals and will also be referred too in the next two sections of the report.

In summary, there was a core group of staff working in the designated centre, with

additional supports from regular relief staff. On the day of the inspection staff were observed to be familiar with the assessed needs of the residents for whom they were providing supports to during planned short breaks. However, due to the findings of this inspection, the inspector was not assured the provider had adequately addressed all of the actions outlined in the compliance plan update from the January 2023 Health Information and Quality Authority (HIQA) inspection submitted by the provider to the Chief Inspector in August 2024. This included ensuring staff were provided with mandatory and centre specific training to support the assessed needs of residents availing of short breaks. It was not evident that the provider had ensured actions outlined under Regulation 23: Governance and management had been completed as outlined to the Chief Inspector following the January 2023 inspection, which outlined monthly staff meetings would be taking place and scheduled performance meetings with staff would be taking place. The inspector was only able to review 25 contracts of care on the day of the inspection of the 45 residents who were listed on the directory of residents as availing of short breaks within the designated centre. The multi-dispciplinary reports for all residents were to be located in one central location, the inspector was unable to review any such reports on the day of the inspection. The clinical governance and oversight regarding medications in relation to prescribed controlled medicines for one resident was not evident since the resident commenced availing of short breaks in the designated centre on 11 June 2024. There were gaps evident in a range of documentation reviewed during the inspection which included the directory of residents, incident records, infection prevention and control records. In addition, actions identified by the provider's own internal audits were found not to have been adequately addressed or completed.

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, while residents spoken with during this inspection reported to the inspector that they were happy and enjoyed their short breaks further improvements were required. The findings of this inspection were not reflective of consistent effective systems in place to monitor and ensure residents consistently received a good quality service. The inspector found evidence of no improvements in compliance in some regulations reviewed during this inspection. This included Regulation 23: Governance and management, Regulation 16: Staff training and development, Regulation 29: Medicines and pharmaceuticals.

The provider had previously informed the Chief Inspector that six monthly internal audits had been missed due to the implementation of an organisation wide electronic monitoring system and changes to the internal provider led audit process

in March 2024. This designated centre was one of these affected centres. The provider had ensured a 2023 annual report had been completed as required by the regulations. Actions had been identified but not all had been progressed or completed at the time of this inspection. The person participating in management had completed an audit of the designated centre in July 2024 which had also identified actions that remained un-resolved from the annual report of 2023 and other internal audits already completed. A detailed action plan was documented following the July 2024 audit. On 6 August 2024 it was documented that the person in charge was to work towards progressing the outstanding actions. This action plan had been reviewed again with the person in charge on 3 September 2024. The actions included for the person in charge to increase formal supervisions and appraisals with the staff team, to ensure all residents contracts of care were in place and the storage of all residents multi-disciplinary reports in a centralised location. The inspector was unable to review any formal staff supervisions or appraisals on the day of the inspection that had taken place since the January 2023 inspection. Contracts of care for 20 residents were not available for review and staff were unable to locate multi-discipilnary reports for residents following a planned scheduled review on 15 August 2024 during the inspection. It was documented in the July 2024 internal audit action plan that staff needed to be able to access information in the event of an un-announced inspection or internal audit taking place.

Staff training was reviewed as part of this focused inspection. The inspector acknowledges that the provider was aware there were gaps in the training of some staff and had expected to be in compliance with Regulation 16: Staff training and development by 30 November 2024 as per the details provided in the updated compliance plan submitted in August 2024. However, due to the findings on the day of the inspection, the inspector was not assured consistent safe medication practices were in place in the designated centre. Not all staff had received training in the safe administration of medications at the time of this inspection. On review of medication documents including the prescription and drug recording sheets of one resident, it was evident prescribed controlled medications were administered outside of the provider's processes, safety protocols and as outlined in the Misuse of Drugs Regulations 1988, as amended. In addition, the person in charge had not ensured staff had been informed that prescribed medications for one resident who commenced attending for short breaks in June 2024 were controlled medications. The inspector noted staff were unaware of the statutory requirements which applied to the controlled medications that had been on -site in the designated centre and documented to have been administered to a resident in the designated centre on at least three occasions during August 2024. The inspector acknowledges that the person participating in management outlined during the inspection the processes that should have been implemented but these did not take place.

In addition, the person in charge was to ensure two nominated social care workers were to be provided with access to the designated centre's on-line compliance trackers as part of the provider's systems of ongoing oversight and monitoring. This on-line access was not available to the social care worker on the day of the inspection. They also did not have access to the updated compliance plan submitted to the Chief Inspector which was also documented as being an action of the July

2024 audit of this designated centre.

During the inspection the person participating in management outlined the provider's future plans to introduce an alternative system of documentation for residents availing of respite services while ensuring all the information required from a regulatory perspective was included. This was described as a "short break passport". It is envisaged that this format would standardise all of the information for residents availing of short breaks within the designated centre.

Regulation 16: Training and staff development

The provider had given assurance in the compliance plan update submitted in August 2024 that actions to ensure compliance with this regulation would be completed by 30 November 2024. Following the January 2023 inspection the provider had outlined actions to attain compliance by 30 April 2023.

- The person in charge had a training matrix of the current staff including relief staff in place. There was evidence of some training being scheduled for staff such as safeguarding and positive behaviour support/safety intervention training in the weeks following this inspection. The inspector reviewed the details contained in the training matrix for the current staff team working in the designated centre. The details for 12 staff had been updated on 20 September 2024 by the person in charge. These included training records for the person in charge, social care workers, care assistants both core staff and relief staff.
- The person participating in management was able to provide updated information during the inspection regarding the training status of some of the staff as they had access to a shared electronic record pertaining to staff training records including staff that worked on relief in the designated centre. The inspector was shown evidence that almost 85% of staff had completed training in human rights.
- The inspector acknowledges that the provider was seeking to address gaps in training that had been identified on internal audits. This included engaging an assessor to complete hand hygiene assessments of the staff team .
- Training records available for review documented training in fire safety had been completed by 75% of the staff team and safeguarding had been completed by over 80%. However, other training for staff that had been deemed to be required to be completed to effectively support the assessed needs of the residents in this designated centre and listed in the current statement of purpose had not been completed by all members of the staff team. This included 58% of the staff team had not completed positive behaviour support/safety intervention training, 25% of the team had not completed training in administering emergency medication and 34% had not completed safe administration of medicines. The inspector acknowledges that the information provided in the updated compliance plan submitted to the Chief Inspector in August 2024, outlined details of planned training to

address gaps in staff training by 30 November 2024.

- Not all staff had been provided with support and training to complete incident forms. As evidenced during the inspection, some of the incident forms that had been documented since 31 August 2024 were found to be incomplete and missing identification details of residents for whom they had been recorded for.
- In addition, the inspector was unable to review any staff supervision records on the day of the inspection. The inspector acknowledges that the provider's own internal audits had identified improvements were required relating to structured supervision of staff in the designated centre but this could not evidenced by staff on the day of the inspection.
- The inspector was informed that regular staff meetings had not taken place during 2024. No rationale for this could be provided to the inspector on the day of the inspection. The inspector acknowledges this issue had been highlighted by the person participating in management in July 2024 and a subsequent staff meeting held in August 2024.The inspector reviewed the documented meeting notes of this staff meeting that had been held on 9 August 2024 with another meeting scheduled for November 2024.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The provider had given assurance to the Chief Inspector in August 2024 in a compliance plan update that the person in charge had updated the directory of residents to ensure it contained all the pertinent information as required by the regulations. The provider also outlined that the directory of residents had been reviewed and updated in July 2024, which included being organised alphabetically.

The provider had a dedicated directory of residents folder in place in the designated centre which was reviewed by the inspector during the inspection.

However, on review of one resident's information contained within the directory of residents not all details as required by Schdeule 3 of the regulations were found to be completed. This included no details of the resident's home address, the name of their general pracitioner, or an address for their family representative. These sections of the form within the directory of residents were blank on the day of the inspection for this resident who had been availing of short breaks in the designated centre since June 2024.

On the day of the inspection, neither the staff team or the inspector could locate any documentation as required under Schedule 3 of the regulations pertaining to a resident who had availed of short breaks in recent months. The inspector had noted the resident's name when reviewing an incident report dated 31 August 2024 but there was no identification number on the incomplete form. When the inspector reviewed the directory of residents to check this resident's details no documents for

a resident with the same name was located.

On the day after this inspection, the inspector was informed by the person participating in management that the resident had a double barrelled surname and the relevant documentation was filed in another part of the directory of residents. However, the incident report that had been partially completed did not refer to the resident using this name format. In addition, on the printed list of residents names used by the inspector during the inspection, there was no double barrelled surname evident for any resident availing of services within the designated centre.

Judgment: Not compliant

Regulation 21: Records

The inspector did not review this regulation in full, but did review the actions outlined by the provider submitted in both the original compliance plan following the January 2023 inspection and the most recent compliance plan update submitted in August 2024 to the Chief Inspector.

The provider had outlined training and supports were to be provided for staff relating to all record keeping which included personal plans and the National Incident Management systems (NIMs). This was in progress at the time of this inspection, 50% of the staff team had completed NIMs training. The provider had outlined to the Chief Inspector that they expected to be in compliance with this regulation by 30 October 2024 in the compliance plan update submitted in August 2024.

Not all records reviewed during the inspection relating to residents had all the information as required by Schedule 3 of the regulations.

The provider outlined actions to ensure that all staff were aware of the systems of record keeping with documents to be reviewed regularly as part of the governance and oversight in the centre. This included a review of admission and discharge documents and discuss issues during staff handover meetings. However, evidence of such reviews or discussions were not available on the day of the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place did not provide assurance that sufficient oversight was in place to ensure that the service was safe and effectively monitored.

This was also identified as a concern in the previous HIQA inspection in January 2023. The provider had plans in place to address concerns identified in previous HIQA inspections and through internal audit findings. However, the provider had not ensured all of the actions outlined in the compliance plan submitted to the Chief Inspector following the January 2023 inspection and the compliance plan update submitted in August 2024 had been adequately addressed or completed within the time lines. This included-:

- Regular staff meetings had not taken place during 2024. One staff meeting had been held in August 2024 with one more scheduled to take place in November 2024. The provider had outlined that monthly staff meetings were to be held in the designated centre following the January 2023 inspection. The most recent compliance plan update in August 2024 outlined a schedule of staff meetings had been put in place.
- Not all staff were in receipt of annual performance management meetings during 2024. On the day of the inspection staff were unaware of their planned supervision schedule. The inspector was unable to determine if a schedule for staff supervision by the person in charge was in place for 2024.
- While the provider had recently recruited two social care workers to enhance the overall governance, management and operational management of the designated centre, due to limits in the electronic permissions and access to some written information for these staff their ability to enhance the ongoing operational management and governance was hindered at the time of this inspection.
- The provider had a centralised system in place which tracked internal regulation 23 audits, annual reviews and HIQA inspections, with a monthly review between the person in charge and the person participating in management. However, some actions identified in the July 2024 audit conducted by the person participating in management and for which the person in charge was responsible to follow up were not evident to have been addressed in a timely manner and remained unresolved or incomplete at the time of this inspection. For example, there were gaps/missing information in documentation such as the directory of residents which was stated to have been reviewed in July 2024.
- Not all documents required to be available for review under the regulations were accessible to the staff team or the inspector on the day of the inspection, this included incident reports prior to the 31 August 2024, contracts of care for all residents availing of services in the designated centre and incident records for the designated centre occurring since 9 January 2023 until 31 August 2024.
- An action identified during the 2023 annual report related to the external garden area to the rear of the property. As part of the action plan review in July 2024 immediate attention was required to the garden space to ensure improved access and safety of residents. However, it was not evident any actions had been completed in the progress update or visually when viewed by the inspector.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had ensured a service level agreement document was developed following the previous HIQA inspection in January 2023. At the time of this inspection, the inspector was informed a total 45 residents were in receipt of short breaks, with a maximum of six residents attending at any one time. On the day of the inspection only 25 contracts of care could be located by staff for the inspector to review. The provider had given assurance in the compliance plan update submitted in August 2024 of actions to ensure compliance with this regulation would be completed by 30 September 2024.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had ensured the statement of purpose had been reviewed following the previous inspection in January 2023. The actions outlined by the provider had been completed. The document had also been subject to a more recent review in July 2024. The provider had ensured the revised document contained correct details such as contact numbers, information pertaining to emergency admissions and emergency procedures. In addition, a statement relating to the staffing ratios in the designated centre had also been included.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had submitted quarterly notifications as per the regulatory requirements since the previous HIQA inspection in January 2023.

The inspector was unable to review any incident forms/records prior to 31 August 2024. The inspector acknowledges this is possibly due to incident forms prior to that date were locked in the secure press in the staff office which could not be opened during the inspection. The inspector was unable to establish during the inspection if all adverse incidents since the previous HIQA inspection in January 2023 which would require written notice within three working days to the Chief Inspector, had been submitted as per the regulatory requirement. This will be actioned under

Regulation 23: Governance and management.

The inspector reviewed incident forms that had been documented by staff in the designated centre since 31 August 2024. While, the incidents reviewed did not require to be reported to the Chief Inspector, not all incident forms had been correctly completed or contained all of the required information in line with the provider's processes. This was discussed during the feedback meeting at the end of the inspection.

Judgment: Compliant

Quality and safety

Overall, the inspector was not assured the systems in place to review and monitor the services being provided were effective at the time of this inspection. While the provider had demonstrated review of systems and monitoring was taking place, not all actions to address issues identified were being completed in a timely manner. In addition, actions that were documented to have been completed were found not to have adequately addressed at the time of this inspection to ensure compliance with the regulations. Issues in relation to Regulation 29: Medicines and pharmaceuticals were discussed during the inspection with the person participating in management and the day after the inspection on the phone with the provider's Chief Operations Officer.

The staff team demonstrated their commitment and dedication to ensuring the safety of residents while providing a homely environment to residents availing of services in the designated centre. This included pre-planning on the day of the inspection to ensure all the required preparations of bedrooms and communal areas were complete in advance of the arrival of residents in the afternoon. On return to the designated centre residents were given the opportunity to discuss what activities they would like to do in the evening and their food preferences.

However, as previously mentioned in this report the social care worker did not have access to some documents that were requested for review which included the most recent multi-disciplinary reports of residents that were scheduled for 15 August 2024. Not all residents information was available for review during the inspection which included personal plans and personal emergency evacuation plans, (PEEPs). For example, there were no documents relating to a resident who had commenced availing of short breaks in July 2024 available for review at the time of the inspection. In addition, as part of the governance and oversight of residents personal plans in the designated centre each resident was to have one personal plan in the designated centre to ensure relevant and up to date information was available. Following the internal audit in July 2024 , a documented action of one resident : one plan had not been fully addressed for all of the residents availing of respite breaks in the designated centre. The provider had outlined in the August

2024 compliance plan update submitted to the Chief Inspector that the aim for ensuring all staff had the most up-to-date information to support each resident safely and appropriately during their respite stay would be aimed to be completed by 31 October 2024.

Regulation 17: Premises

The provider had ensured the premises was designed and laid out to meet the needs of the residents attending for short breaks. This included accessible spaces in downstairs communal areas and a downstairs bedroom for residents who had issues with their mobility.

The provider had progressed with the replacement of fire doors throughout the designated centre. Decorative painting had commenced with all ceilings completed and plans to have the internal walls & door frames painted in the weeks after this inspection. The provider had previously informed the Chief Inspector in the compliance plan update of August 2024 that the aim was for these works to be completed by the end of September 2024. The inspector acknowledges that while this time line was not met at the time of this inspection, there was evidence of substantial progress begin made.

The issue regarding the external area to the rear of the premises was not part of the previous inspection findings under this regulation and had been identified by the provider's internal audits and reviews of requiring immediate action. This will be actioned under Regulation 23: Governance and management

Judgment: Substantially compliant

Regulation 20: Information for residents

The provider had ensured the residents guide for this designated centre had been subject to review. The most recent review was completed in July 2024 and available for the residents in a suitable format. Easy-to-read information was also available for residents to consult with regarding the national standards, advocacy and human rights.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had outlined in the August 2024 compliance plan update submitted to the Chief Inspector that a review of the risk register had been completed with the most recent review completed by the person in charge in June 2024. However, the findings during this inspection did not provide assurance that the provider ensured there were effective systems in place for the assessment, management and ongoing review of risk. This was also a finding of the previous HIQA inspection in January 2023.

- The risk of medication errors had been reviewed in June 2024 with control measures documented to be in place which included staff training in safe administration of medications. However, it was not evident that control measures documented to be in place were subject to review in the event of a change or incident occurring. This included the administration of prescribed controlled medicines which had occurred on at least three occasions during August 2024 in the designated centre. The risk of potential harm to residents as a result of non adherence to specific protocols and regulations pertaining to controlled medications had not been identified in the designated centre.
- Another medication error had also occurred in the designated centre in the days prior to this inspection. On 29 September 2024 the night manager had to ensure the well being of one resident who had received an incorrect dose of their prescribed medication. The resident was monitored and subsequently deemed to have not been adversely affected by the error made. However, the management of the risk of harm to residents due to medication errors occurring in the designated centre and effective control measures in place required further review.
- Pre-admission checklists were being completed as part of the new admission and discharge protocols to ensure that the team had the most up-to-date information to support each resident safely and appropriately. The inspector acknowledges the provider is actively progressing with a specific short breaks document which will include a review of individual risk assessments.
- However, on the day of the inspection not all residents individual risk assessments were available for review.
- In addition, following a review by the inspector of a documented incident where a resident had removed their seat belt while travelling in a transport vehicle on 20 September 2024, there was no update or review post the incident recorded in the resident's individual risk assessment regarding their safety while travelling on a transport vehicle.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had outlined actions to attain compliance with this regulation which

included an updated Infection prevention and control information folder, repair to damaged surfaces and regular checking of the first aid box in the designated centre. These actions were found to have been completed at the time of this inspection.

However, during this inspection, the inspector observed multiple checklists relating to day time cleaning schedules. These were being completed inconsistently by staff. Some staff were completing one checklist while others were completing another. There were gaps in the records reviewed documenting the daily cleaning taking place. In addition, not all staff were aware of the requirement to complete a weekly checklist to reduce the risk of Legionnaires disease. The checklist reviewed by the inspector documented checks being completed on the week commencing 25 March 2024, the previous check to that was documented as taking place on the week starting 1 September 2023. More recent checks were being completed by staff but this was not consistently each week. For example checks were completed on 13 September 2024 and not repeated again until 23 September 2024.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspector did not review all aspects of this regulation during this inspection. The focus was on reviewing the actions outlined by the provider to the Chief Inspector to attain compliance with this regulation following the last inspection in January 2023 and in the compliance plan update submitted in August 2024.

- All exits were observed to be un-obstructed during the inspection.
- The provider had identified that three staff would require refresher training before the end of 2024 in the updated compliance plan submitted in August 2024. The person in charge was delegated this action to ensure this was addressed within the time frames.
- The provider had actively progressed with the replacement of fire doors throughout the designated centre and all associated structural works to ensure effective fire safety measures were in place.
- In July 2024, the person participating in management had reviewed the personal emergency evacuation plans (PEEPs) for all residents and had identified actions which were required to be completed by the person in charge to ensure all information was up-to-date for each resident. However, on the day of the inspection the inspector was unable to review the PEEP for one resident who had been in receipt of services in recent months. The inspector was informed on the day after the inspection that this document was in place for the resident.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured that the designated centre had the appropriate and suitable practices relating to the storage and administration of controlled medicines in accordance with the provider's own protocols and procedures and the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

- Not all staff were trained in the safe administration of medicines in the designated centre.
- From the drug recording records provided to the inspector during the inspection, staff in the designated centre had not followed the required protocols regarding controlled medications. This included only one staff signature documented on the recording sheet of the administered controlled medications on at least three occasions to a resident which was not in-line with the safe administration of this prescribed medication or the provider's protocols. On the day of the inspection, the inspector was unable to review incident forms prior to 31 August 2024 and it was unclear if an incident had been recorded for these adverse events.
- The person in charge had not made the staff team aware of the specific arrangements required to be adhered to regarding the prescribed controlled medications.
- Controlled medications had been brought to and kept in the designated centre without being correctly stored or documented /recorded. For example, there was no specific locked area inside a locked press when the controlled medicines were on the premises on 7 August 2024. There was no documentation or recording of the details of the controlled medicines including the name, dosage and number of tablets. No counting of the number of tablets of the controlled drugs had taken place at the beginning of each shift in the designated centre. This resident had commenced availing of short breaks in the designated centre on 11 June 2024.
- While the person in charge had requested a medication safe on 14 August 2024 and this was installed on the 19 August 2024, the staff team were not informed or aware of the processes for them to be in receipt of or administer the controlled medication as per the provider's medication policy and the Misuse of Drugs Regulations 1988, as amended.
- The provider had outlined actions taken since the previous HIQA inspection to attain compliance with this regulation which included a review of the medication policy and the introduction of admission and discharge checklists to support good practice in relation to the receipt, storage administration, documentation and return of medications for all residents availing of respite services in the designated centre. However, at the time of this inspection this was found not to be consistently adhered to at all times in recent months.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider had outlined actions to attain compliance with this regulation which included a review of the current systems in operation regarding residents support plans whilst attending for respite services. The provider had given assurance in the compliance plan update submitted in August 2024 that actions to ensure compliance with this regulation would be completed by 31st October 2024.

The provider had outlined systems in place for the regular review of residents personal plans in conjunction with the residents, representatives, day service staff and multi-disciplianary teams where required.

A key worker system was in operation in the designated centre and all key workers were to link with relevant day services by 31 August 2024. The person in charge was to ensure all personal information was provided to support residents in receipt of services in addition to their primary care plans. The person participating in management had requested in July 2024 a robust and full review of personal plans in the designated centre ensuring one person : one plan. This was not yet completed at the time of this inspection. While details of planned multi-disciplinary meetings were available on the notice board in the staff room, no multi-disciplinary reports were available in a central location for review by the inspector on the day of the inspection. This was an action identified in the provider's internal July 2024 audit.

In addition, on the day of the inspection staff were unable to locate the personal plans and other relevant documentation for one resident who was in receipt of short breaks during July, August and September 2024. The inspector was informed the day after the inspection that these documents were on site in the designated centre.

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 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant

Compliance Plan for East County Cork 2 OSV-0003290

Inspection ID: MON-0044554

Date of inspection: 02/10/2024

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

- 3 staff require Positive Behaviour Support training. The Person in Charge has requested training dates from PBS department. Training scheduled for Tuesday 19th November. 2 out of 3 staff will complete training on this date. The Person in Charge will schedule dates for remaining staff once dates become available.
- Safety intervention training dates will be available from 2025. 5 staff require training. The Person in Charge will schedule training for staff once dates become available.
- The Person in Charge will ensure that the centre has 24/7 cover for the administration of medication. Training is ongoing for staff and the Person in Charge will ensure that dates are scheduled as they become available.
- The Person in Charge will ensure that the centre has 24/7 cover for administration of buccal midazolam if required. Training is ongoing for staff and the Person in Charge will ensure that dates are scheduled for staff as they become available.
- The Person in Charge has commenced formal supervision of the staff team since the inspection and performance reviews are ongoing with aim for full completion by the end of November.
- The Person in Charge has developed a schedule of monthly team meetings and schedule is available for staff to review. The Person in Charge will ensure that minutes of meetings are maintained, with clear actions identified and evidence of follow up at subsequent meetings. Minutes will be available onsite for staff to review. New protocol and template for staff meetings has been developed and shared with Person in Charge to implement in the centre.
- Staff training on completion of NIMS forms is ongoing.

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
• Directory of Residents has been reviewed by the Person in Charge following the inspection and all gaps with missing information have been filled.
• Social Care Worker will develop local protocol whereby night staff on duty in the centre are responsible for completing the Directory of Residents each night. The Person in Charge will ensure that all staff are aware of the protocol once it is completed.
• Prior to any new resident being admitted to the centre, the Person in Charge will ensure that Directory of Residents documentation is in place with all required information.
• The Person in Charge will review the centres Directory of Residents on a quarterly basis to ensure all information is being recorded as per regulatory requirements.
• In relation to residents with double barreled surnames, it has been decided that their information will be stored in alphabetical order under the first of the two names. The Person in Charge will ensure that all staff are aware of this to avoid any future errors in relation to storage of records.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Staff are completing NIMS training on HSE-land to ensure accurate recording of incidents in the centre and that all required sections of NIMS forms are completed in full. The Person in Charge will review all NIMS on a weekly basis (or sooner if required in the event of incidents requiring statutory notification), to ensure that all relevant sections are completed including any follow up actions required and signed off by the reporting staff member.
• The Person in Charge and Social Care Workers will review admission and discharge checklists on a weekly basis to ensure that staff are completing all relevant sections and support staff as required with training and / or enhanced supervision to ensure that checklists are completed in full.
• The PPIM has finalized a 'Short Breaks Passport' template since the inspection and staff team have commenced compiling one for each individual who avails of respite in the centre. 13 Short Breaks Passports have been completed so far.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • A schedule of monthly staff meetings has been put in place and the Person in Charge will ensure that meetings are held as per schedule with minutes and clear actions identified. The Person in Charge will send staff meeting schedule to PPIM who will also attend meetings where possible. • Schedule of performance reviews has been put in place and is available for review in the centre. The Person in Charge will ensure that performance reviews are completed as per schedule. • Social Care Workers now have access to the shared electronic system which holds training matrix and compliance trackers for HIQA reports and regulation 23 internal audit action plans. The Person in Charge will ensure that SCW's receive training and guidance in relation to reviewing and updating compliance trackers for the centre. • External garden area has been highlighted to facilities manager and contractor coming onsite in the coming days to clear weeds and carry out a thorough clean of the external garden area. The Person in Charge has also liaised with the volunteer coordinator to add the centre to the volunteer list should any opportunity arise for the garden to be decorated by a voluntary group in the near future. • The Person in Charge has sent out blank contracts of care to families / service users whose contracts were missing and is awaiting return of same. The Person in Charge will ensure to follow up so that all signed contracts are returned by the end of the year. The Person in Charge will also ensure that any new resident to the centre has a signed contract in place prior to commencing overnight respite.	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • The Person in Charge has sent out blank contracts of care to families / service users whose contracts were missing and awaiting return of same. The Person in Charge will ensure to follow up so that all signed contracts are returned by the end of the year. The Person in Charge will also ensure that any new resident to the centre has a signed contract in place prior to commencing overnight respite.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

• All works on fire doors have been completed. • Painting to commence in the coming weeks. • External garden area has been highlighted to facilities manager and contractor coming onsite in the coming days to clear weeds and carry out a thorough clean of the external garden area. The Person in Charge has liaised with volunteer coordinator to add the centre to the volunteer list should any opportunity arise for the garden to be decorated.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Since the inspection a site-specific controlled medication protocol has been developed and implemented the centre in adherence with organizational policy in relation to the receipt, storage and administration of controlled medications. Further controls implemented to mitigate against the risks associated with the receipt, storage and administration of controlled medications include; - Controlled medication site specific protocol reviewed and agreed by PPIM, Assistant Director of Nursing and the Person in Charge. - Protocol has been discussed and reviewed with all team members in the centre. - All team members have signed off on the review and their understanding of the protocol. - The Person in Charge will conduct regular reviews of the controlled drug register in the centre. - The Person in Charge will ensure that the protocol is reviewed with all staff prior to admission of any resident that is prescribed controlled medication(s). The Person in Charge will also ensure to review all medication records for residents prescribed controlled medication(s) on discharge. • Individual risk assessments are being reviewed by the Person in Charge and Social Care Workers on the team as part of short breaks passport development for each person availing of respite in the centre. • As part of the weekly NIMS review carried out by the Person in Charge, risk assessments for individual residents will be reviewed / updated as required in the event of additional controls required for the person.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection

against infection:
• Cleaning and other IPC checklists have been streamlined since the inspection and staff are now completing daily / nightly checklists for cleaning.
• A legionella checklist and protocol are in place and staff agreed on Wednesdays for completion.
• Social Care Worker has been assigned responsibility for weekly auditing of all IPC checklists.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The Person in Charge will ensure that the centre has 24/7 cover for the administration of medication. Training is ongoing for staff and the Person in Charge will ensure that dates are scheduled as they become available.
• The Person in Charge will ensure that the centre has 24/7 cover for administration of buccal midazolam. Training is ongoing for staff and the Person in Charge will ensure that dates are scheduled for staff as they become available.
• The Person in Charge and Social Care Workers will review admission and discharge checklists on a weekly basis to ensure that staff are completing all relevant sections and support staff as required with training and / or enhanced supervision to ensure that checklists are completed in full. Any discrepancies in relation to records of medication being signed in and out will be addressed by the Person in Charge with the relevant team members immediately.
• Since the inspection a controlled medication protocol has been implemented in adherence to organizational policy in relation to the receipt, storage and administration of controlled medications. Controlled medication protocol has been reviewed by PPIM, Assistant Director of Nursing and the Person in Charge. Protocol has been discussed and reviewed with all team members in the centre.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• Since the inspection PPIM has finalized 'Short Breaks Passport' template and team in ECC2 have commenced compiling one for each respite user in the centre. To date 13 passports have been completed and work is ongoing in relation to full completion of all

passports.
• The Person in Charge and PPIM are reviewing status of completion at scheduled bi-weekly 1:1 meetings and aim for full completion of all Short Break Passports by the end of March 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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2024
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	31/01/2025
Regulation 19(3)	The directory shall include the information specified in	Not Compliant	Orange	30/11/2024

	paragraph (3) of Schedule 3.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	28/02/2025
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/12/2024
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	28/02/2025
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	Not Compliant	Orange	30/11/2024

	personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	31/12/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/12/2024
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of	Substantially Compliant	Yellow	30/11/2024

	healthcare associated infections published by the Authority.			
Regulation 29(4)(a)	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 any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	30/11/2024
Regulation 29(4)(d)	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 storage and disposal of out of date. unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988 (S.I. No. 328 of 1988), as	Not Compliant	Orange	30/11/2024

	amended.			
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.	Substantially Compliant	Yellow	28/02/2025
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	28/02/2025