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

Issued by the Chief Inspector

Name of designated centre:	Cork City South 2
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	22 October 2024
Centre ID:	OSV-0003295
Fieldwork ID:	MON-0045077

About the designated centre

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

The centre is registered to provide a home for up to 25 male and female adult residents and is based on a campus on the south side of a large city. Services provided include full time residential supports for 21 residents. Short breaks/respite services were also being provided to over 30 residents. Currently, a maximum of two residents at a time are supported to attend for a short break in the designated centre. In addition to the centre, the campus also has sports fields and a large day service facility on site. All of the residents in receipt of residential services have high support needs, with most residents needing assistance with all activities of daily living including support with nutritional needs and personal care. Many residents also have complex healthcare needs including epilepsy and mobility problems. The centre consisted of two large interconnected bungalows. All residents are supported in single occupancy bedrooms. Bungalow one can support up to 11 residents, one of the bedrooms is allocated for use by residents availing of short breaks. This part of the centre also has a large bright foyer. There is a visitor's space located along the communal hallway and a large sitting room. There is a kitchen area and a dining room, a shower room and a bathroom. Bungalow two provides a home to nine full-time residents with one bedroom used by residents for short breaks. This part of the centre has a kitchen area, a dining room and a large sitting room, a staff office, a staff changing area, a sensory room, a personal care / beauty room, two shower rooms, two toilets and a storage room. The staff team comprises of nursing staff, care assistants, household and activities co-ordinators. Residents are supported by the staff team by day and with waking staff at night time.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

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 22 October 2024	10:00hrs to 18:45hrs	Elaine McKeown	Lead
Tuesday 22 October 2024	10:00hrs to 18:45hrs	Conor Dennehy	Support

What residents told us and what inspectors observed

This was an un-announced adult safeguarding inspection completed within the designated centre Cork City South 2. The centre was registered with a maximum capacity of 25 adults. At the time of the inspection 21 residents were in receipt of services which included two in receipt of short breaks. The designated centre had previously been inspected in July 2023. There had been a number of actions identified during that inspection that required a non -standard condition of registration to be added to the renewal of the designated centre's current registration cycle which began on 4 January 2024. The provider is to address the regulatory non-compliance to the satisfaction of the Chief Inspector not later than 31 December 2026.

This inspection was conducted as part of the Chief Inspector's programme of focused inspections pertaining to the safeguarding of adults. The inspectors acknowledge some positive outcomes were evident since the previous inspection which included all residents were being supported in single- occupancy bedrooms. During the inspection, 19 residents were met with by either one or both of the inspectors. One resident who had begun transitioning into the designated centre since August 2024 returned in the afternoon and another resident was at home with relatives. The inspectors also spoke at different times during the inspection to 11 members of the staff team, this included the person participating in management, the person in charge, nursing staff both qualified and students, health care assistants which included one who had responsibility for the kitchen duties including meal preparation on the day of the inspection.

Shortly after arrival in the centre, inspectors did an initial walk through of the centre before holding an introduction meeting with the person in charge. During the walk through it was seen that residents were being supported with their early morning routines by staff members who introduced some of these residents to the inspectors in communal spaces. Most of these residents did not directly interact with inspectors at this time. Near the end of the walk through inspectors met a resident who was availing of a short break in the designated centre. The resident was sitting on a couch in a living room. This resident smiled at inspectors when greeted and shook both inspectors’ hands. It was observed that the resident had a small bag on the floor beside the couch. A staff member informed inspectors that this resident had been waiting since 8:15am to be picked up to attend their day services. When an inspector returned to this living room at 11am it was observed that this resident was no longer there. However, the inspectors were informed later in the day that the resident had not attended their day service on the day of inspection due to a mis-communication between the day service and staff team. The staff team including the activation staff engaged with the resident during the day to provide some meaningful activities and interactions with others.

Soon after this another resident was briefly met having their breakfast in one of the centre’s dining rooms. A staff member was observed providing the resident with a

'Nice to meet you' document which explained who the inspector was and why he was in the resident's home. After the resident had finished their breakfast, the inspector returned to the resident who indicated that they wanted to speak with the inspector. When the inspector sat down, the resident started to ask a staff member present questions about the inspector. The staff member had a good understanding of what the resident was communicating and responded clearly to each of the questions. Given the nature of the questions that the resident was asking, the inspector suggested to the resident that he leave and return to the resident at a later time. The resident beckoned at the inspector to sit down and with some reassurance provided from a staff member, the resident relaxed.

During the conversation the resident indicated that they liked living in the centre but was unable to give specific examples of this. However, they did have positive responses relating to the staff team and the supports provided. The resident showed the inspector a sticker book that they had in front of them at the time when asked what were they planning to do for the day. When the inspector asked the resident who they would talk to if they were unhappy about something, the resident called another staff member and asked this staff member to tell the inspector about their wheelchair and a named staff member. The staff member present informed the inspector that the named staff member usually worked with the resident but was on leave and that the resident's wheelchair needed to be sorted. This will be further discussed in the quality and safety section of this report.

The resident also suggested that they show the inspector their bedroom which was located nearby. This bedroom was seen to be nicely presented and furnished with the resident having their own television. The resident then pointed to a picture on the wall with the staff member going on to speak about who this was a picture off. The resident then returned to asking a staff member similar questions to those they had made earlier about the inspector. The staff member was observed to respond in a manner consistent with how the first staff member had answered the resident's earlier questions. The inspector thanked the resident for showing him their bedroom and left the resident at this time. The inspector did see the resident multiple times during the remainder of inspection with the resident again heard to ask staff present similar questions about the inspector. Staff were heard to respond to these consistently on each occasion.

Other bedrooms within the designated centre were observed by inspectors to be decorated with personal possessions, nicely presented and furnished. This included improved wardrobe storage facilities which had been previously identified as requiring review during the July 2023 inspection. In addition, all residents availing of residential or respite services within the designated centre had their own bedroom. There were no more shared bedrooms in the designated centre which had been in place at the time of the previous inspection in July 2023. The person in charge outlined the process undertaken to support residents to be happy with the changes to their bedrooms which included a change of location to another bedroom for one resident who expressed their unhappiness with their initial bedroom to staff familiar with the resident and how they communicated their feelings.

Throughout the designated centre, communal spaces such as the dining and living

rooms were found to be well-presented and well-furnished with various Halloween decorations on display in the centre. As had been observed during the July 2023 inspection, the assigned visitors' area for the centre was located in an open area in one of the centre's corridors. The location of this visitors' area could make it difficult for residents to receive visitors in private outside of their bedrooms if they wished to do so. However, the provider had outlined in a compliance plan update in October 2024 that a number of alternatives were under review to address this issue. The inspectors did observe some minor maintenance issues in a number of bathrooms in the designated centre which be discussed further under Regulation 17: Premises.

Throughout the inspection, the atmosphere in the centre was generally quiet with some residents being involved in activation within the centre, leaving the centre to attend a day service on the same campus or going for a walk. Of the residents that were met by the inspectors, the majority did not communicate verbally or engage directly with inspectors. At times though some residents did interact briefly with inspectors. For example, one resident handed an inspector a soft toy they were using, another resident held onto an inspector's hand and a third resident called to an inspector as he passed their open bedroom. While residents were in the centre it was seen that they were supported with meals, did some colouring, listened to music or watched television. It was particularly noticeable that in one of the centre's living rooms, one particular television programme was being shown throughout the day. Residents generally appeared content although towards the end of the inspection, it was noted that one resident, who was in a comfy chair with wheels propelled themselves a long distance from one part of the centre to the other. A staff member did check on this resident while speaking with an inspector but it was unclear if the resident was being supervised or required supervision during this time.

Since the previous inspection, all residents availing of full time residential services had been supported to have a holiday. For example, three residents had enjoyed a short break to an adventure centre which was described as having a positive impact on their lives. The residents and staff were able to participate in activities such as river rides which were new experiences. One of these residents had displayed their enjoyment in a number of ways while interacting with members of the multi-disciplinary team on their return. The person in charge outlined other short breaks of either one or two nights that had taken place during 2024 where residents had been supported by familiar staff to experience community and social activities. The inspectors were informed that for over 12 months all residents were frequently offered the opportunity to avail of weekly recreational swimming in line with their will and preference. Staff informed the inspectors how one resident who had previously declined to engage in such activities was attending in recent months and enjoying the experience. Staff also facilitated residents to visit family members in their own homes, one such visit was planned for the day after this inspection. Other family members visited frequently to spend time with their relative in the designated centre.

Staff had also made complaints on behalf of the residents when activities had to be cancelled due to the shortage of staffing resources within the designated centre. For example, two residents were unable to attend their planned hydrotherapy session on 27 August 2024. Another complaint was made by staff in February 2024 relating

to the staffing levels over the week end of 17 and 18 February. The complaint was submitted by six staff members who documented their concerns regarding the available staffing resources which was described in the complaint as adversely impacting on the ability of the staff team to engage in meaningful activities and provide high standards of care to 21 residents with complex care needs. The issue relating to the staffing resources was as result of unprecedented sick leave and additional supports required by three residents who had contracted COVID-19 and required to be supported in their bedrooms while adhering to infection protection and control precautions. It was acknowledged in the complaint that the person in charge had made repeated requests for additional staffing resources.

In summary, there was evidence of progress being made in relation to the safeguarding of residents and their rights since the previous inspection. It was evident residents were being supported to attend day services more frequently on a rotational basis. This resulted in increased opportunities for more residents to engage in activities outside of the designated centre since the previous inspection. The inspectors acknowledge that this arrangement was in place while the provider sought to address staffing resource issues within the provider's day service on the same campus. The two activation staff had actively worked with the staff team, supporting residents to identify and achieve goals and participate in meaningful activities within the designated centre which included music and pet therapy. Each resident in receipt of full time residential services was being supported by two key workers whose roles and responsibilities were being developed to enhance and ensure progress being made was being documented to reflect the work being completed, this included photographs and memory books. However, the challenge to ensure consistent and adequate staffing levels familiar with the assessed needs of the residents remained an issue at the time of this inspection.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being provided.

Capacity and capability

Overall, this inspection found that residents were in receipt of care and support from a dedicated staff team. There was evidence of oversight and monitoring within the designated centre. The provider had taken actions to progress towards and attain compliance regarding a number of issues identified during the previous inspection by inspectors of social services on behalf of the Chief Inspector in July 2023. This included planned upgrade fire safety works scheduled to take place during 2025.

During this inspection the person in charge demonstrated how the provider had systems through which staff were recruited and trained, to ensure they were aware of and competent to carry out their roles and responsibilities in supporting residents

in the centre. This included ensuring staff had up-to-date knowledge on the effective safeguarding of residents while supporting their human rights. The person in charge was aware that two staff out of the total of 38 staff required to complete refresher training in safeguarding and one new staff was to complete the training at the time of this inspection. Residents were being supported by a core team of staff members, which included nursing and health care assistants. During the inspection, the inspectors observed kind, caring and respectful interactions between residents and staff. Residents were observed to appear comfortable and content in the presence of staff, and to seek them out for support as required. For example, one resident sought staff support to explain to one inspector the current issues regarding their wheelchair.

All residents living in this centre had either complex medical and/or high support needs, with many residents needing the support of two staff members for certain tasks such as personal care and transfers. An escalated risk related to staffing in this centre had been previously identified and this escalated risk remained active at the time of this inspection. Based on observations and discussions with staff and management during this inspection, it was evident that ensuring appropriate staffing arrangements to support residents was challenging.

Throughout this inspection it was seen that front-line staff were kept very busy in various tasks such as supporting residents, preparing meals and completing paperwork. Inspectors were informed that a minimum staffing level of nine staff was needed during the day however staff spoken with and rosters reviewed indicated that there could be times when staffing levels were lower than this. Staff highlighted that staffing shortages raised issues in the centre while some staff members spoken with indicated that minimum staffing level of nine staff was not always enough to adequately support residents. In doing so concerns were raised around the ability to engage residents in meaningful activities and from a safety perspective it was highlighted that it could be difficult to adequately supervise residents for which staff were providing support.

For example, on one date reviewed, a clinical nurse manager was the only qualified nurse on duty with seven healthcare assistants, an activation staff was on duty from 09:00hrs until 18:00 hrs. On the day of this inspection, there were three nurses and four health care assistants on duty. There was also a pre- registration nurse working until 17:00 hrs and an activation staff until 16:00 hrs. There was no dedicated staffing supports for one resident due to planned leave of that staff member. The inspectors acknowledge that the person in charge was also scheduled to work from 08:00hrs until 20:00 hrs. However, this resulted in only eight staff rostered to be working in the designated centre after 17:00 hrs to support the assessed needs of 20 residents present in the designated centre who required high levels of support with activities of daily living (ADLs). This also included some residents requiring the support of two staff to meet their assessed needs. One full time resident was at home at the time of this inspection with relatives.

The inspectors were informed that the provider had systems in place where staff from other designated centres could be asked to provide support and assistance if necessary. For example, on another date noted, 21 residents were being provided

with support from seven staff in the morning and 18 residents were supported by six staff in the afternoon. This included the person in charge and clinical nurse manager. This had resulted due to unplanned leave of staff and other core staff had been assigned to support three residents to have a short break for two nights.

The inspectors acknowledge the provider had reviewed the staffing resources required to support the assessed needs of the residents since the previous inspection. However, there were challenges being experienced by the staff team at the time of this inspection. While the priority was to ensure the safety, supervision and assessed needs of the residents were being met additional duties which included cleaning, laundry and meal preparation were also required to be completed. These were observed to be ongoing throughout the inspection. The provider had identified in the statement of purpose the role of care assistants to attend to these duties as part of the overall staff team. During the inspection, a staff member who had responsibility for preparing the meals in one of the kitchens outlined the specific needs of the residents, the requirements to ensure the correct consistency of each resident's meal and the other duties they were responsible for. They also outlined the difficulties encountered by the staff team to effectively complete the tasks associated with the safe preparation of meals in both kitchens while also supporting the residents with other activities of daily living.

The person in charge outlined the effective communication that was in place with the provider's short breaks co-ordinator when scheduling respite breaks for over 30 individuals. This included the provision of home support staff when needed to support the assessed needs of respite residents. For example, a dedicated waking staff at night time was provided for two residents availing of short breaks within the designated centre. Since the previous inspection, all bedrooms were now single occupancy which meant all residents attending for short breaks no longer had to share with another person. This assisted with the improved safeguarding of individuals rights during respite breaks, including undisturbed sleep. The inspectors were informed that the person participating in management and the person in charge had planned to complete a compatibility study and an assessment of the respite services within the designated centre in the weeks after this inspection. This action had also been outlined in the provider's compliance plan update of the July 2023 inspection that was submitted to the Chief Inspector in October 2024.

Regulation 15: Staffing

There was evidence of review taking place since the July 2023 inspection by the provider regarding the staffing resources, qualifications and skill mix of the staff team reflective of the number and assessed needs of the residents in receipt of services in the designated centre, the statement of purpose and the design and layout of the designated centre. The inspectors acknowledge the provider had sought to address the actions outlined in the compliance plan response submitted to

the Chief Inspector following the July 2023 inspection, which included rosters reflecting all staff working in the designated centre and a minimal staffing simulation drill was completed with an external consultant present in August 2023 with a report and recommendations made available to the provider. In addition, the two activation staff working within the designated centre facilitated residents to engage more frequently in meaningful activities both in the community and in the designated centre. The provider had also made organisational changes during 2024 to the reliance on agency staff which was evidenced in this designated centre.

However, challenges remained to be addressed regarding staffing resources to ensure the consistent safeguarding of residents in receipt of services within the designated centre.

- The provider had identified during internal audits in June, July and August 2024 the requirement for experienced staff to be available to support new or relief staff to ensure the assessed needs and preferred routines of residents were being supported in a consistent manner. Inspectors were informed that the clinical nurse managers and the person in charge provided front line support at times of reduced staff resources. This was observed to be required on the day of the inspection.
- While one nursing post was scheduled to be filled the week after this inspection, there remained gaps in experienced staffing resources due to the long term planned and unplanned leave of three staff members at the time of this inspection. There were three relief health care assistants providing regular assistance at the time of this inspection.
- The dedicated staff resource for one resident was not available on the day of the inspection due to the person taking planned leave which led to a reduction in the opportunities for the resident to engage in meaningful activities. A family member visited the resident in the afternoon and supported them to go out for a walk around the campus grounds.
- The demands on the staff team were observed during the inspection to continue to be high which included the provision of full time supports such as ensuring safe transfers and assistance with ADLs for most of the residents.
- Increased duties for the staff team such as cleaning were in place since September 2024
- The minimal number of nine staffing resources identified by the provider and documented in the statement of purpose was not consistently maintained to ensure the provision of safe and effective services to all residents.

Judgment: Not compliant

Regulation 16: Training and staff development

At the time of this inspection 38 staff members including the person in charge worked regularly in the designated centre. This included three regular relief health care assistants, 19 health care assistants and 14 nurses. Student nurses were also

provided with placements and mentoring within the designated centre.

The person in charge had ensured a training matrix reflective of each staff members training requirements was maintained and subject to regular review. One inspector reviewed this matrix which indicated the majority of staff had completed a range of training courses to ensure they had the appropriate levels of knowledge, skills and competencies to best support residents while ensuring their safety and safeguarding them from all forms of abuse. These included training in mandatory areas such as safeguarding and children's first. Other training courses either completed or in progress by the staff team included advocacy, assisted decision making, cyber awareness, open disclosures, human rights and general data protection regulation.

The person in charge had ensured all staff were aware of the on-line courses that they were expected to complete, this included annual fire safety which 19 staff had been sent links to complete in the weeks after this inspection. Staff were also being supported to avail of training in positive risk assessments and developing personal goals using a rights based approach. Seven staff nurses had completed the perceptorship training to support student nurses.

The plans for future staff development was also outlined to the inspectors which included increased delegation of responsibilities to the key worker role, such as up-to-date documentation and goal identification along with recording progression of recording personal goals with residents.

However, due to issues relating to staffing resources scheduled training could not always be attended as planned by staff members due to the requirements/assessed needs of the residents in the designated centre. The person in charge had scheduled refresher training for some staff in advance of the previous training expiring but training had to be rescheduled due to the unavailability of sufficient staff resources this included refresher training in safeguarding for two core staff and one new staff member. This will be actioned under Regulation 23: Governance and management

The person in charge had completed annual supervisions with the staff team during 2023 in -line with the provider's policy. They outlined during the inspection, their plan to compete the annual supervisions for 2024 during a specific two week period for the whole staff team with support from the two clinical nurse managers.

The person in charge ensured regular staff meetings were taking place which included meetings for the core staff team, other meetings with the nursing staff and a meeting with the activation staff during 2024. The meeting notes were reflective of ensuring the safeguarding of residents with discussions around the requirements of when to submit an incident form, nail care to reduce the risk of self harm and nutritional needs of residents.

Judgment: Compliant

Regulation 23: Governance and management

The provider was found to have governance and management systems in place to oversee and monitor the quality and safety of the care of residents in the centre. There was a management structure in place, with staff members reporting to the person in charge. The person in charge was also supported in their role by a senior managers within the organisation. The provider had ensured the designated centre was subject to review of the services being provided, the delivery of care and support in accordance with the assessed needs of the residents and the statement of purpose. This included monthly audits which the person in charge had oversight of to ensure all actions were addressed in a timely manner.

The provider had ensured policies were in place and available to the staff team regarding the safeguarding of residents. This included safeguarding vulnerable persons at risk of abuse which had been subject to review in September 2023. The provider also had a risk management policy which had been reviewed in October 2023. This included references that "the management of risk is the concern of every staff member" and outlined the systems in place for the identification, responsibilities of staff and the ongoing review process throughout the organisation including senior management and the board of directors. The safeguarding of residents was referenced in the policy in a number of areas including considering the service users experience and the risk of aggression. The policy also outlined the structured mechanisms in place to monitor and review the effectiveness of risk management strategies, plans and processes.

The person in charge ensured the staff team were aware of their obligations under the Health Act 2007, which included ongoing review of safeguarding plans and protocols in place within the designated centre. There was guidance in place and risk assessments which were subject to regular and recent review to ensure the effectiveness and consistent approach of the staff team.

Further information about the designated officer had been put up in the centre following a safeguarding self-assessment that had been completed by the person in charge in May 2024. This self-assessment was based on relevant nationals standards.

Staff were facilitated to attend regular bi-monthly meetings, these were usually completed in the presence of the person in charge. The inspector reviewed a sample of three recent meetings in August and September 2024. The meetings were used as an opportunity to discuss the supports needs of residents and any known safeguarding concerns were discussed. The responsibilities of the staff team were consistently discussed as well as training requirements and dignity at work.

However, due to ongoing challenges of staffing resources not all staff were able to attend scheduled training, including safeguarding training as planned due to the needs of the residents in the designated centre.

Judgment: Substantially compliant

Quality and safety

The inspectors noted that the staff team and provider demonstrated some improvements for residents regarding their quality of life since the July 2023 inspection. This included ongoing review of resident's expressed wishes either verbal or non-verbal regarding engaging in day services and choices in their daily lives. However, further review to risk assessments was required. This was in relation to a thickening agent being used within the designated centre, required by some residents for the safe consumption of fluids. There was a risk of harm to residents due to practices within the designated centre on the day of the inspection. This will be actioned under Regulation 26: Risk management procedures

Throughout the inspection, staff members were observed to support and interact with residents in a respectful manner. To enhance the safeguarding of residents in all aspects of their lives there were protocols in place. This included guidance for staff within residents' individualised personal plans relating to intimate personal care. This is important in helping preserve the dignity of residents when providing care in this area. Residents' personal plans also had assessments around areas such as self-administration of medicines and around their finances. Restrictions had been identified for residents relating to their finances but it was highlighted that measures had been put in place for some residents to increase their access to and have control over their own finances. Since the previous inspection, the sharing of bedrooms between some residents had ceased. This was a positive development.

The majority of the residents living this centre did not communicate verbally and it was highlighted by the person in charge that a pilot programme had recently commenced to give residents more ways to communicate their wishes during resident forum meetings. This included having the voice of the resident heard by using assistive technology such as electronic tablet devices, a sounder on a wheel chair and sign language. Input from the speech and language therapist was also part of this workstream. A review of the format of the residents meeting forums was also in progress to give residents more ways to communicate their wishes during such meetings.

Some information was contained within residents' individualised personal plans which provided guidance for staff in how individual residents communicated. It was noted though that such information was guidance and one resident's personal plan made explicit reference to the resident having a communication passport. An inspector queried if the resident had a communication passport but the person in charge indicated that they did not. It was highlighted though that the pilot programme ongoing for the centre could result in this resident getting a new communication passport. However, the inspectors acknowledge that staff supporting this resident were observed to have a good understanding of the resident's communication needs on the day of inspection. For another resident, an inspector queried how they communicated with a staff member who demonstrated a strong awareness in this area.

During this inspection, an inspector met one resident who appeared anxious related to their wheelchair. The same inspector later spoke with a relative of this resident who highlighted that the resident's current wheelchair was too heavy for them which limited their independence. As a result the relative had to bring another wheelchair to the centre in order to bring the resident out for walks from the centre. This is what was observed on the day of the inspection. The relative also indicated that the resident had been waiting on a wheelchair "for ages" and that this was upsetting the resident. When later queried with the person in charge, it was confirmed that the resident had been waiting on their new wheelchair since January 2024 and it was unknown when it would be available to the resident. However, it was acknowledged that the person in charge had being seeking updates on the status of the wheelchair in the time leading up to this inspection.

The staff team were continuing to support respite breaks in the centre. On the day of the inspection two residents were in receipt of respite breaks. The staff team provided ensured one of these resident's was included in activities during the day when they had not been able to attend their own day service as planned due to a communication error. The person in charge outlined how they linked regularly with the short break co-ordinator to ensure the assessed needs of those residents attending for short breaks were being adequately met while not adversely impacting on the residents in receipt of full time residential services.

Regulation 10: Communication

The provider had ensured residents had access to telephone, television and Internet services in the designated centre.

Residents were being supported to communicate using preferred methods which included keys, sign language and assistive technology.

Staff were observed to be familiar with individual residents preferred methods of communication and demonstrated knowledge of when a resident may be presenting with pain or other discomforts.

Visual aids were used frequently to support choice making, for example when making meal choices.

The provider had commenced an organisational work stream to review effective communication methods for residents and this designated centre was part of the pilot programme.

Speech and language referrals had been made on behalf of the residents and these were in progress at the time of the inspection

Judgment: Compliant

Regulation 17: Premises

This designated centre was comprised of a large premises and overall the premises was seen to be presented in a clean, well-maintained and well-presented manner on the day of inspection. All residents now had their own their own individual bedrooms and five of these seen by inspectors were observed to nicely decorated, well-furnished and personalised. For example, some bedrooms had televisions, family photos and storage facilities provided. Efforts had also been made to make the premises homely with various Halloween decorations seen to be display around the centre. In addition, the provider had outlined in an update provided to the Chief Inspector in October 2024 that they were seeking to further address the provision of a private space for visitors to meet with residents.

However, some areas for improvement were noted particularly related to the bathrooms in the centre.

- These included presses being chipped or water damaged and a rusted radiator.
- Also some bathroom areas needed further cleaning. For example, what appeared to be mould was evident in the tile work of one bathroom while in another bathroom a ceiling vent was visibly unclean. In the latter bathroom, there was gaps evident in the records of the daily cleaning of this bathroom, some dates in October 2024 no entries had been made.
- At times during the inspection, wheelchairs were observed to be stored in some bathrooms with one of these bathrooms noted to be cluttered. It was also indicated that wheelchairs would be stored in bathrooms at night as there was no other storage space available.
  It was acknowledged that maintenance requests had been previously made by the person in charge to address some of the issues identified regarding the bathrooms. These requests were pending at the time of inspection.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had ensured there were systems in place for the assessment, management and ongoing review of risk within the designated centre. The designated centre had an overall risk register and identified risks related to individual residents were outlined in risk assessments that were contained within residents' individualised personal plans.

However, during the inspection it was observed that a product required to thicken

fluids for residents with dysphagia was located on a unit in one of the dining rooms with additional supplies of the product also stored in the nearby kitchen which was also easily accessible. Staff spoken to were unaware of the safety protocols required to be in place with regards the product which included being kept in a locked press to reduce the risk of harm if ingested. Also, this was not in-line with the recommended safe storage of such a product as outlined by the Nursing and Midwifery board of Ireland (NMBI) guidance to nurses and midwives on medication management, August 2020. This guidance is referenced in the provider's own administration of medication policy, November 2022. This product is given to residents for special medical purposes and should be stored in a secure manner in a locked cupboard. In addition, due to the location of the product the risk of a resident ingesting the product had not been identified. While most of the full time residential residents required full support with their ADLs including mobilising as some residents attend for respite breaks, the inspectors were not assured the storage of the product had been assessed and safe practices were in place to ensure the safety of all residents.

The provider had taken actions to address issues identified in the July 2023 inspection which included completing a minimal staffing fire drill and a review completed by an external person competent in fire safety.

The centre’s risk register was subject to regular review with the most recent completed in May 2024. When an inspector reviewed the personal plans of two residents, it was evident that all risks assessments within these plans had not been reviewed in a timely manner. For example, some risk assessments had due dates for review in 2023 but had not been reviewed in line with these dates and this included a risk that had been assessed as a red/high risk. Some risk assessments had also not been reviewed and updated to take account of changes in circumstances. This included one resident who had a risk assessment in place around the risks to privacy from sharing a bedroom. Other documentation reviewed in this resident’s personal plan indicated that they had not been sharing a bedroom since June 2024. When such risk assessments were queried with the person in charge, it was suggested that these resident specific risk assessments may have been in the process of being reviewed and updated.

The person in charge outlined the rationale for three risks relating to staff, respite services and fire which had been escalated to senior management. The inspectors were provided with updates on actions and progress being made to review and address the issues in these escalated risks.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plans of five residents were reviewed by inspectors during this inspection. These plans were found to contain some recently reviewed guidance on

supporting residents, particularly regarding their health needs. These plans were also subject to an annual multidisciplinary review which included input from various health and social care professionals such as nursing staff, SLT, psychiatry and occupational therapy. It was noted though that residents were not directly involved in these annual multidisciplinary review.

Other documentation reviewed within residents' personal plans did indicate though that residents and their representatives were involved in a person-centred planning process. This process was used to identify short-term and long-term goals for residents to achieve. In all five personal plans reviewed it was noted that residents had a person-centred planning meeting completed during 2024 where goals for the residents were identified. However, variance was observed in the personal plans reviewed on how the goals identified had been followed. The person-centred planning documents provided indicated that some goals had been achieved such as holidays. These included photographs of some of the residents engaging in and enjoying positive experiences. However, for other residents, there was limited documented evidence in the residents' personal plans on how or if identified goals had been progress. For example, one resident had six goals identified but there were no entries in any goal review sheet for the resident. In some instances no responsibilities and/or time frames were assigned for supporting residents achieve their goals.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The person in charge had processes in place to ensure staff were provided with up-to-date training, knowledge and skills to effectively support residents for whom they were supporting. Three staff were scheduled to attend refresher training in the area of positive behaviour support in November 2024 and a review of a blended crisis prevention intervention training and de-escalation was under review at the time of this inspection given the assessed needs of some residents.

Inspectors were also informed that an instructor in de-escalation and intervention had recently spoken to the staff team in the centre to given additional guidance in this area. However, when reviewing documentation relating to an incident, it was noted that there had been a recommendation made in May 2024 for a protocol on disengagements from one resident in particular situations to be carried out and reflected in the resident's personal plan. An inspector reviewed this resident's personal plan and found no reference in this. When queried it was indicated that such a protocol was not yet in place although attempts had been made to obtain same.

During the introduction meeting for this inspection, inspectors were informed that only resident in the centre had a positive behaviour support plan. The plan documented the date of the last review being completed in December 2022 and

outlined particular responses that staff were to give to the resident in specific situation. During the inspection, staff were seen to follow the guidance outlined in this positive behaviour support plan. It was highlighted though by the person in charge that this plan required updating to provide additional guidance for staff on how to respond to the resident in a particular situation. A request for a review of this plan had been made but it was unknown when this would take place.

A number of restrictive practices were in use in this centre including locked presses and keypads. Processes were in place to review such restrictive practices and documentation reviewed indicated that these restrictions had been reviewed in recent months. Inspectors did not observe any restrictive practice in use in the centre other than those that were outlined in restrictive practices documentation reviewed during this inspection. Such restrictive practices had also been appropriately notified to the Chief Inspector of Social Services

Judgment: Compliant

Regulation 8: Protection

Given the focus of this inspection, safeguarding practices were considered with the following identified;

- The provider had a safeguarding of vulnerable adults policy. This policy had been reviewed in September 2023 and was in line with relevant national policy. In keeping with this policy the provider had designated officer in place and contact information about this person was on display in the centre.
- Staff members spoken with were also aware of the identity of the designated officer. Such staff also demonstrated a good awareness of how report safeguarding concerns that they had.
- Training records reviewed during this inspection indicated that 90% staff working in the centre had completed relevant safeguarding training.
- Staff had raised concerns and made complaints on behalf of the residents relating to the provision of safe services and high standards of care within the designated centre.
- Where any incidents or allegations of an alleged safeguarding nature had occurred or been, relevant referrals made to the Health Service Executive Safeguarding and Protection Team with safeguarding plans put in place. Such safeguarding plans outlined measures to safeguard residents which included measures such as continuous supervision of residents in communal areas. Copies of these safeguarding plans were contained within an overall safeguarding folder for the centre and in involved residents' personal plans. While these plans contained some relevant information, they had not been reviewed in over 12 months and needing updating in some areas.
- Intimate care plans were found to be reflective of the residents assessed

needs.
- Residents were provided with information in appropriate formats to make them aware of safeguarding such s during advocacy meetings
- Easy-to-read information around safeguarding for residents was also contained within the overall safeguarding folder.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had taken actions since the July 2023 inspection to ensure residents were being supported in line with their expressed wishes and be engaged in meaningful activities more frequently. This included all residents had their own single occupancy bedrooms when availing of services in the designated centre. Choice was evidenced to have been offered to one resident when they expressed they were not happy with a move to a bedroom and the staff team ensured another bedroom was provided which the resident indicated they were happy with. This did not adversely impact any other resident.

While the provider sought to address staffing resource issues within it's day services located nearby on the same campus a rotational schedule each week was organised for residents to attend this day service. This in conjunction with two dedicated activation staff in the designated centre facilitated access to more frequent meaningful activities both within the designated centre and in the community. This included music therapy, pet therapy as well as weekly swimming.

The staff team had supported all full time residents to avail of a short break/holiday in the previous 12 months. This was evidenced in photographs, personal goals and memory books.

The staff team had held summer and birthday parties which family members were invited to attend. In addition, the week following this inspection a family forum and information sharing event was planned in the designated centre.

There was ongoing communication and planning with the staff team and the short breaks co-ordinator to ensure the compatibility of residents attending for short breaks with residents in full time residential services.

The inspectors were informed of the scheduled compatibility assessment that was expected to be completed by the end of December 2024.

One resident expressed to an inspector how they were waiting since January 2024 for a new wheelchair which would improve their comfort and mobility. The inspectors acknowledge that the person in charge had made repeated attempts to seek a resolution to this matter to the satisfaction of the resident but remained unresolved at the time of the inspection.

However, the same resident did not have the freedom to engage in activities of their choice in the days prior to and including the day of this inspection due to the planned leave of the dedicated staff resource which was assigned to support them. This had beenactionedunder Regulation 15: Staffing

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cork City South 2 OSV-0003295

Inspection ID: MON-0045077

Date of inspection: 22/10/2024

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• The PIC supported by the PPIM and the HR department for the Registered Provider will ensure all vacancies in the center are filled. 'Approval to hire' forms as part of the Registered Providers recruitment process have been completed for all vacancies in the center at present time. Recruitment has commenced for all vacancies in the center.
Time frame for completion 30/06/2025

• The PIC and PPIM have had a specific meeting in relation to staffing in the center, an action out of this meeting is to develop the relief panel for the center so that residents and the permanent staff team can be supported by a consistent and reliable relief staff team for the center. Approval to hire forms have been complete and sent to the HR department for the Registered Provider to increase the number of relief staff for the center.
Time frame for completion 30/06/2025

• The PIC and PPIM have had a specific meeting in relation to staffing in the center, an action out of this meeting is to provide volunteers for the center so that the residents and staff team can be supported by volunteers in the center for outings and social activities for the residents. The PIC will contact the volunteer coordinator for the Registered Provider with the aim of recruiting volunteers for the center.
Time frame for completion 30/06/2025

• The PIC, PPIM and ADON for the center have been in consultation in relation to staffing in the center, the current allocation and skill mix of staffing was reviewed. An action out of this consultation is to develop a business case to be submitted to the HSE to request a modified staffing allocation and skill mix for the center. A the HSE to request a modified staffing allocation and skill mix for the center. A HSE consultant (Head of Service, Transformation and Reform) who has been appointed to the Registered Provider, has scheduled appointments with the PIC and PPIM to support them in the process of

developing the business case for the HSE to increase the staffing and skill mix for the center. This is a part of an overall service improvement plan for the center to be completed by the end 2026.
Time frame for completion of the business case 30/06/2025

Regulation 23: Governance and management	Substantially Compliant

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

• The PIC will ensure that staff are afforded the time to complete all trainings required as they fall due. The PIC will complete a review of trainings in the center and will instruct the staff to complete mandatory online trainings during times when it is less busy in the center, for example at night. For all mandatory training that is required in person, the PIC will request support from the DON/ADON and other appropriate training coordinators to provide this training as a priority to staff in the center where needed.
Time frame for completion 30/06/25

• The PIC and PPIM (as highlighted in Regulation 15, Staffing above) have had a specific meeting in relation to staffing in the center, actions out of this meeting are for the PIC and PPIM to work with the HR department for the Registered Provider to fill all vacancies in the center. In addition to develop the relief panel for the center so that residents and the permanent staff team can be supported by a consistent and reliable relief staff team for the center. The PIC will also contact the volunteer coordinator for the Registered Provider with the aim of recruiting volunteers for the center. Approval to hire forms have been complete and sent to the HR department for the Registered Provider to increase the number of relief staffing and to fill the vacancies for the center.
Time frame for completion 30/06/2025

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• The Registered Provider has commenced a process in the centre where the management of the centre are going to do a full review of all maintenance requests previously submitted to the maintenance department.
Time frame for completion 31/12/2024
• The PIC will ensure that all outstanding maintenance requests identified are completed in an appropriate time frame. This is to include the repair or replacment of presses that are chipped or water damaged and radiators that have rust on them. In addition flooring and tiling in bathrooms that have been identified as being in need of being replaced will be identified to the Facilities Officer so that a plan can be scheduled to complete these works.
Timeframe for completion 30/09/2025
• As part of the Service Providers new audit schedule, an environmental audit has been scheduled for twice yearly to capture all maintenance and environmental issues in the centre. This is in addition to the local cleaning schedule that is completed in the centre on a weekly basis. Cleaning schedules and all other matters in relation to infection,

prevention and control will continue to be discussed regularly at staff team meetings.
A nominated staff member in the centre will be assisgsned the responsibility of ensuring that all cleaning schedules are being completed and that all cleaning in the centre is being carried out as per the cleaning schedule.
Time frame for completion 31/12/2024
• The Register Provider has also commenced a monthly meeting between the PPIM and the Facilities Officer for the Register Provider to discuss all maintenance issues with the centre.
This process has commenced as of November 2024.

• The PIC will ensure that a periodic schedule for deep cleaning of high risk areas in the centre be put in place, this is to include areas such as bathrooms to ensure an adequate deep cleaning of such areas is carried out by suitably qualified cleaning personnel.
Time frame for completion 31/12/2024

• The PIC and PPIM are reviewing the current allocation of contracted cleaning hours for the center in conjunction with the Facilities Officer and Finance Dept for the Registered Provider.
Time frame for completion 30/06/2025

• The PIC will ensure that an assessment is carried out in the centre for suitable storage space for all wheelchairs to be stored at nights and during the day when residents go for rests. From the results of this assessment a protocol will be put in place in the centre to ensure wheelchairs are stored in suitable environments within the centre and in close proxmity to the residents while they are asleep or on rest breaks. The aim of this assessment is to reduce the clutter in the bathrooms as much as possible as well as identifing other suitable areas in the centre to store wheelchairs.
Time frame for completion 31/01/2025

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• The PIC will update a local protocol in relation to the storage of medications in the center, this will include the storage of medications in a safe manner during times where they are not being used. This will include the safe storage of liquid thickeners used as part of FEDs recommendations by the S< department for residents. This action has commenced already in the center.
• Time Frame for completion 05/12/2025

• As part of the Register Providers audit schedule an audit of all risks will take place in the center quarterly by the management team of the center. This will include all risk assessments in the risk register and all individual risk assessments for residents. The PIC will ensure as apart of this audit schedule that all risks are appropriate, all existing control measures and additional control measures are accurate and that all risks are reviewed in the appropriate time frame.
Time frame for completion 28/02/2025

• In addition, the PIC and PPIM will discuss all risks in the center as part of the their scheduled one to one meeting. This will include all previously escalated risks to the PPIM for their support in managing all risk including escalated risks in the center.
• Time frame for completion 31/12/2025

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:

• The PIC will ensure that residents in the center have the opportunity to participate in their MDT reviews on an annual basis. The PIC will facilitate individualized advocacy meetings with residents and their staff team as advocates where their MDT process will be discussed with the resident and their will and preferences captured in relation to their MDT supports offered by the Register Provider. This will be done using advocacy forms specific to the resident.
Time Frame for completion 31/08/2025

• The PIC is to put in place a new tracking template when new PCP are being completed that records the dates of person-centered planning meetings, review meetings and due dates for future review meetings for all residents living in the designated center.
Time frame for completion 31/05/2025
• A nominated staff member in the center will be assigned the responsibility of ensuring that all PCP documentation is being completed as per schedule.
Time Frame for completion for appointing this role 31/12/24

• As part of the Service Providers new audit schedule, Personal Plan audits have been scheduled for four times per year, this audit is to include Person Center Planning documentation.
Time Frame for completion of personal plan and PCP documentation 30/04/2025

• The Registered Provider in conjunction with a Quality Improvement Group established by the Registered Provider will be introducting a new key worker policy and supporting training which is planned to be available by the end of the 2024. The PIC will ensure all staff have knowledge and training of this policy when it is rolled out.
Time frame for completion 31/07/2025

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Substantially Compliant	Yellow	30/06/2025

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/06/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	28/02/2025
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the	Substantially Compliant	Yellow	31/05/2025

	resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident’s wishes, age and the nature of his or her disability.			
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	31/08/2025