Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 3
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	16 December 2024
Centre ID:	OSV-0003697
Fieldwork ID:	MON-0045512

About the designated centre

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

The designated centre was purpose built to provide a home to 20 adult residents with complex care needs, behaviours that challenge and mental health difficulties. The centre comprises of three purpose-built inter-linked units (bungalows) on a campus style setting on the outskirts of a city. These units have a shared paved area to the rear, garden and ground area to the front and was located adjacent to a dedicated day centre / day service for residents. The units each have a kitchen and dining area, a sitting room, single bedrooms accommodating each resident and bathroom facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

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
Monday 16 December 2024	09:40hrs to 18:00hrs	Deirdre Duggan	Lead
Monday 16 December 2024	09:40hrs to 18:00hrs	Robert Hennessy	Support
Monday 16 December 2024	09:40hrs to 18:00hrs	Kerrie O'Halloran	Support

What residents told us and what inspectors observed

From what inspectors observed during this inspection some improvements had taken place since the previous inspection. The day-to-day care needs of residents in this centre continued to be met and for the most part, residents were seen to be happy in their homes. Residents lived experiences continue to be impacted by some ongoing issues in the centre including incompatibility, but progress was noted with the providers plan to address these issues. Staffing levels and consistency of staff appeared to have improved since the previous inspection and it was noted that this was contributing to an overall calmer atmosphere in the centre. While some improvements were noted with access to the community and appropriate access to activity for residents, some issues remained in this area.

The centre comprises three purpose built interconnected single-storey units located in a gated campus setting. There is a day service building located on the campus also and this is accessible to the residents living in the centre. There were 18 residents living in the centre at time of this inspection and two vacancies. One bungalow was home to seven residents, one to six, and one to five. Some residents were on weekend visits to their families when the inspection commenced and two of these returned to the centre later in the day. One resident was not present in the centre during the inspection. All residents have their own bedrooms. Bathroom, kitchen and laundry facilities are shared.

Overall the centre was seen to be well maintained, clean, bright and homely. The houses had all been decorated for Christmas and it was seen that efforts were made to ensure that this was a special time for residents. Residents bedrooms were personalised and one resident showed an inspector new furniture that they had recently picked out for their room. Flooring had been replaced in a number of areas in the centre since the previous inspection and couches had been replaced. Work had been carried out to renovate some of the bathrooms also.

Inspectors spent time in each house and spoke with staff and residents in all houses, reviewed documentation and observed interactions and practices in each unit. Inspectors met with or observed sixteen residents on the day of the inspection. An inspector also met with two family members. On the morning of the inspection, residents were observed to attend the on-site day service building if they wished. Residents could remain in their houses if they preferred. Some residents were in bed and were observed to get up at a time of their own choosing and have breakfast.

Staff were present to support residents in their homes throughout the day and returned to their homes at mealtimes. Midday hot meals are provided from the providers' central kitchen located external to this campus and other meals are prepared on site by staff or residents themselves. It was observed that residents had choices about when to have their meals and that staff supported some residents to heat up or prepare meals if they did not wish to eat at the same time as their peers. In the house that had the most residents, it was seen that meals were

offered in a planned manner and this appeared to support a quieter environment for some residents.

Some residents requested to speak with inspectors and this was facilitated. Residents also consented to inspectors joining them as they enjoyed refreshments and meals and spent time in the communal areas of their homes. Some residents chose not to interact at length with inspectors and this wish was respected.

Most residents' spoken with told the inspectors that they were happy living in the centre and liked their homes. One resident told an inspector that they were moving out soon and were happy about this as they would feel safer in their own house. They told the inspector about picking out furnishings such as flooring on the Internet with the person in charge. Residents spoke in a positive way about the staff that supported them and interactions between staff and residents were seen to be respectful and relaxed.

Residents told inspectors about their lives in the centre, the things they enjoyed and some recent activities and outings they had been on. One resident showed an inspector pictures of a recent shopping trip they had been on. Another resident, supported by staff, communicated about Christmas and recent activities such as attending a light display and pantomine and making decorations in the house. Residents were observed to be well presented. Some residents showed inspectors new clothes, footwear and jewellery and told the inspector that they had either went shopping for these themselves or had ordered them online. One resident told an inspector that they were now able to access the centre transport and had resumed going out regularly.

Some residents were observed to leave the centre for planned activities during the day. Inspectors saw that some residents however, spent a significant amount or all of the day on the campus. While activities such as games and tabletop activities were offered in the day service, while in their homes residents tended to watch TV, listen to music or walk around the house or campus. One resident was preparing to go swimming on the evening of the inspection and was looking forward to this. Some residents were encouraged to complete household and activities of daily living tasks by staff. Staff were seen to be aware of residents communication styles and preferences.

However, some negative interactions were also observed between residents and it was clear from what residents and staff told the inspector that some residents did not like living with some of the people that they shared their homes with. For example, some residents were anxious about the inspector speaking with other residents and were heard to speak negatively about the people they shared a home with.

Two family members who visited the centre on the day of the inspection spoke with an inspector. The feedback provided was very positive about the centre. They told the inspector that the centre was a 'happy place', was 'home' to their relative and that they were very satisfied with the care and support offered in the centre and that they felt their relative was safe and very well looked after. They told the

inspector that the staff were 'extraordinary' and spoke about some of the strategies staff had used to support their relative, who had lived in this centre for over 25 years. They reported that the management team were responsive to any concerns they had and that communication from the centre was very good.

Overall, this inspection found that further improvements were evident since the previous inspection but there was ongoing non-compliance with the regulations. This meant that residents were still not at all times being afforded safe and person centred services that met their assessed needs. However, the provider had made progress with the timebound plan submitted to the Chief Inspector which outlined a long term plan to bring the centre into compliance.

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

Capacity and capability

Management systems were in place in the centre that supported overall adequate day-to-day care and support of residents. Appropriate premises and staffing levels were in place to provide for residents needs and residents presented as happy in their homes. This inspection found that while some progress had been made with the provider's compliance plan that would have a positive impact for residents, non compliance remained across a number of regulations including general welfare and development, staff training and development and governance and management.

The previous inspection of this centre took place in November 2023, with ongoing non compliance noted at that time, although some improvements were evident. Following this, the provider submitted a timebound plan to the chief inspector detailing how they planned to bring the centre into compliance and the registration of the centre was renewed with an additional condition attached that required the provider address the regulatory compliance to the satisfaction of the Office of the Chief Inspector by January 2027. This risk based inspection was carried out with a focus to assess the provider's progress with the plan submitted to the Chief Inspector.

There was a clear management structure present in this centre. Some management changes had occurred since the previous inspection and the management structure in the centre had changed. The person in charge now had remit over this centre only, and was now supported by one Clinical Nurse Manager 1 (CNM1). This post was temporarily vacant at the time of the inspection and the provider had not filled this position in the interim. The person in charge reported to a person participating in the management of the centre, a regional manager.

The person in charge was present in the centre on the day of this unannounced

inspection. The PPIM also made themselves available and were present in the centre on the day of the inspection. Both of these individuals met with inspectors and facilitated the inspection throughout the day. The role of the person in charge was supernumerary and they were based in an office on the same campus of the designated centre. Inspectors saw that this individual was available to residents, staff and family members throughout the day. The person in charge told inspectors about a recent training course they had completed and how this would contribute to ongoing improvements in the centre.

Overall, inspectors saw that progress was being made and that the provider had taken a number of actions that would contribute to bringing the centre into compliance. A staffing review had been completed and efforts made to provide a consistent staff team to residents and to fill identified vacancies. A new wheelchair accessible bus was now available and this could be accessed by all residents on the campus. For some residents, this reduced the reliance on the availability of taxis or buses from other locations managed by the provider. The provider had worked with one resident to source a community based house and this was being prepared for registration at the time of the inspection. This would reduce the resident numbers in one house.

Staffing in the centre were seen to be have improved since the previous inspection and overall this was seen to contribute good day-to-day care and support for residents. Staff spoken to during this inspection told inspectors that they were well supported in the centre and that the management team were responsive to any issues that arose. A staff supervision schedule was viewed that showed staff were taking part in formal supervision.

However, despite improvements across a number of areas, ongoing non compliance was found during this inspection. Some of this was contributed to by issues that were outside of the providers control, such as timely access to appropriate community based housing for residents to transition into and these were planned to be addressed by the timebound planned mentioned above. However, some oversight issues were also identified. For example, some staff were working in the centre without having completed important mandatory training, including safeguarding training. Further progress was required to ensure that the service provided to residents was at all times safe, consistent and effective and that residents were being offered appropriate opportunities to be active members of their local community and have ordinary lived experiences included in their daily lives.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

A planned and actual staff rota was maintained in the centre and a sample of this rota was reviewed. The centre was staffed by a core team of suitably skilled staff. Overall the roster demonstrated that a consistent staff team provided continuity of care for residents. Staffing was in line with the statement of purpose for the centre. Residents were supported by a team consisting of nursing staff and health care assistants. Relief or agency staff provided supports if required to fill any vacancies that arose.

At the time of the inspection, staffing levels were appropriate to the number of residents living in the centre and to meet the assessed needs of residents present in the centre. Inspectors saw and were told that staffing levels had improved since the previous inspection. 1:1 staffing was being consistently provided to a resident that was assessed as requiring this support. Staff recruitment was ongoing and the person in charge spoke about this to inspectors.

Judgment: Compliant

Regulation 16: Training and staff development

An inspector was provided with and reviewed a staff training matrix that showed the training received by staff in the centre. The person in charge had not fully ensured that staff had access to appropriate training, including refresher training. The previous inspections of this centre had found issues in this area also and the provider had submitted a compliance plan outlining how this would be addressed. While some improvements were noted overall, non compliance remained in this area. A number of mandatory staff trainings had not been completed by all staff, and some refresher training was overdue also. For example, six staff had not received training in Safeguarding, ten staff had not received training in positive behaviour support, five staff had not received training in manual handing and three staff were overdue fire safety training.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the designated centre. There was evidence that the provider was progressing with a long term plan to improve the lived experiences of residents in this centre through a process of decongregation. One resident was due to move out of the centre in early 2025 and there were active efforts to source and obtain suitable accommodation for a number of other residents so that they could commence a transition process also. However, management systems in place had not yet fully ensured that service provided was safe, appropriate to residents' needs, consistent and effectively monitored. Although

overall, further improvements were noted during this inspection, this inspection found ongoing non compliance with the regulations.

The provider had monitoring systems in place that continued to identify specific issues. The providers system of monitoring through audits had been changed since the previous inspection with a new audit programme had been developed by the quality and safety team. At the time of this inspection, there was no evidence to demonstrate that some of these audits had been completed in the centre as per the providers timeframes. Local audits were viewed for two houses that showed some audits were being completed but did not have evidence for others. The person in charge told the inspectors that audits were not entered on an online system. However, they were unable to provide any evidence that a number of audits had been completed as per the providers audit schedule, including audits of personal possessions, medication, residents' finances and fire safety.

However, at the time of this inspection, incompatibility issues remained in the centre and these were impacting on the ability of the provider to ensure a safe and effective service that met the assessed needs of all residents living in the centre. Also, some actions that were due to have been completed as per the previous compliance plan submitted had not yet been fully completed. This included ongoing staff training issues. Full oversight of these issues was not demonstrated during this inspection. For example, some staff had commenced working in the centre prior to completing safeguarding training. Also, while there did appear to be an improvement in the level of activitiy provided to residents in the centre, further improvements were required to ensure that the management team were identifying and taking action where residents did not have equal and consistent access to occupation and activation that met their needs and that all efforts were being made to reduce the potential for peer to peer safeguarding incidents.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints policy and this was viewed on display in the hallway of the centre. Easy-to-read guidance in relation to how to make a complaint was available to the residents and was viewed on display in the centre. Staff spoken with working in the centre presented as familiar with the complaints procedures in place.

The complaints log was reviewed by an inspector in the centre. It was seen that complaints were recorded as appropriate in this log, including any actions taken on foot of the complaint, the outcome of the complaint, and the satisfaction of the complainant. There were no open complaints recorded at the time of this inspection.

Judgment: Compliant

Quality and safety

The quality and safety of the service provided to residents living in this centre was reviewed by inspectors. Findings indicated that overall day-to-day care and support remained good for residents in the centre. Progress had been made since the previous inspection with addressing identified issues and the findings indicated that this had led to improved outcomes for the residents living there. However, further action was required to ensure that safe and good quality services were provided to all of the residents that lived in this centre and that the services provided would fully ensure the ongoing wellbeing and welfare of all residents.

Some planned transitions from the centre were seen to be likely contribute to an improved lived experience for all residents living in the centre. However, at the time of the inspection, residents' lived experiences continued to be impacted by incompatibility issues and a lack of access to appropriate activation and meaningful occupation for some residents.

Staff and management spoke respectfully about residents and told the inspectors about some of the improvements that had taken place in the centre in the previous year and how this had impacted on residents. Staff were seen to be committed to the residents that they supported and warm and supportive interactions were observed by the inspectors. Residents were observed to be content and happy in their home and enhancements and ongoing maintenance had been completed on the premises since the previous inspection.

Residents were supported by a core familiar and consistent staff team who were seen to be committed and responsive to residents' needs and familiar with care plans, positive behaviour supports and eating and drinking plans in place for residents.

The staff team was made up of nursing staff and care assistants. Usually at least two to three staff supported residents in each house by day and one waking staff was available in each house by night. One resident was supported on a 1:1 basis by day. Floating staff members also provided additional supports as required and student nursing staff also worked in the centre providing additional supports. There were four vehicles available to residents also, including a new wheelchair accessible bus. This meant that residents had increased opportunities to take part in community based activities very regularly but the evidence on this inspection did not show that this was happening for all residents.

Overall, inspectors saw that residents were provided with good care and support to meet their day-to-day needs, and in particular were afforded very good healthcare and personal care supports. As found on previous inspections, healthcare plans reviewed were overall good and provided good guidance for staff. An eating feeding and drinking plan reviewed for one resident provided good information and an inspector observed staff prepare this resident a drink in line with the guidance in

place.

The inspectors viewed a number of documents throughout the day of the inspection, including a sample of residents' most recent assessments of need, person centred plans, support plans and positive behaviour support guidance. Sustained improvements were noted overall in the documentation in place during this inspection. However, the centre was still not fully meeting the assessed needs of all residents due to incompatibility and inappropriate placement issues in the centre. As mentioned previously in this report, the provider was making progress with the overall plan in place to address some of these issues but at the time of this inspection, resident cohorts remained as they had been during the previous inspection.

While there was evidence of some residents attending a pantomine, the cinema, horse riding, baking, swimming, and going on shopping trips prior to Christmas, inspectors found that the amount of activation offered varied for residents and also between the houses in the centre. Also, opportunities to leave the campus did not appear to be consistent for all residents.

Most residents now had access to their finances and records viewed showed residents were spending their own money. Transactions were double signed and all receipts were retained. Safeguarding plans were in place for residents and staff spoken with had a good awareness of safeguarding procedures and of the safeguarding plans in place. Despite this, peer-to-peer incidents continued to occur regularly in the centre due to resident incompatibility.

Some residents had recommendations detailed in their files such as offering regular occupation and activity to residents to reduce the potential for boredom and responsive behaviours. Inspectors saw that on the day of this inspection, some of these residents spent significant periods in their homes watching TV or walking around the campus and the documentation in place indicated that this was usual for these residents. This was also a finding on the previous inspection. This meant that potential for safeguarding concerns was increased and that these residents were not being afforded regular access to appropriate and meaningful occupation in their daily lives.

Regulation 13: General welfare and development

The registered provider had not fully ensured that all residents were consistently and regularly provided with adequate opportunities to participate in activities in accordance with their interests, capacities and developmental needs. The registered provider had also not ensured that the designated centre was providing supports to all residents to develop and maintain links with the wider community in accordance with their wishes.

As found on the previous inspection of the centre, some residents were regularly offered and took part in opportunities to leave the centre for planned activities,

personal development and leisure. Residents were supported to maintain relationships with friends and family. However, while some progress had been made in the centre, such as an additional wheelchair bus for transport, further improvements were still required. For example, in one unit, resident records showed that they were very regularly taking part in external activities and were active in their local communities. However, in the other units, while residents were all leaving the centre on occasion and some improvement was noted in the quality of activities provided, some residents' activity records documented that this remained sporadic in nature and indicated that there were regular periods where residents did not leave the campus for a number of weeks at a time. The only documented internal activities for some residents were television and music and external activities tended to be bus drives, home visits or walks with little evidence that residents were taking part in or being offered community based activities as an ordinary part of daily life.

One resident was heard to tell staff about a number of community activities that they had taken part with while at home and pictures of these activities were viewed in their plans However, the evidence suggested that they were not provided with regular opportunities to take part in similar activities while living in the centre. An inspector reviewed this residents activity and personal planning records and saw that these did not demonstrate that positive risk taking was occurring for this resident and that community access was limited at times for them. While this residents' goals included community based goals, there was little evidence to demonstrate meaningful efforts to achieve these goals. For example, goals included going swimming and going to the local church, which was within walking distance of the centre, to light a candle. These goals had been ongoing for significant periods of time with no progress documented or no attempts to progress these evident.

Judgment: Not compliant

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. The centre was seen to be accessible to the residents that lived there. The overall standard of accomodation was seen to be good and residents were provided with nicely furnished homes, personalised bedrooms and homely communal areas.

A walk around of the premises was completed by the inspectors. Resident bedrooms and living areas were seen to be decorated in a manner that reflected the individual preferences of residents. The centre was observed to be clean on the day of the inspection and overall communal areas were seen to be homely and welcoming. There was suitable outdoor areas available for the use of residents. Some residents had chosen their own furniture and had access to suitable storage. Residents had access to laundry and appropriate waste facilities also. No issues were observed or reported in relation to the ventilation or heating in the centre and natural lighting was sufficient. Some improvements had been made since the previous inspection.

For example, flooring had been replaced, some shower and bathrooms had been refurbished and new couches were observed in some communal areas of the centre.

Some further attention was required to ensure that all areas were well maintained. A large bathroom tile was missing from the wall of one bathroom. Some rusting was noted around a number of bathroom fittings and areas of black residue were noted around some shower seals and tiling.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A sample of seven personal plans were reviewed during the inspection. Plans reviewed reflected residents' assessed needs and there was evidence that a process to review and audit these was underway by the local management team in the centre. An audit sheet at the front of each plan documented the progress with this audit and showed that efforts were being made to maintain oversight over residents' plans.

The person in charge had ensured that appropriate assessments were completed of the health, personal and social care needs of each resident. Annual multidisciplinary team reviews were viewed in residents' files.

The registered provider had made progress since the previous inspection with their plans to ensure that the centre was suitable for the purposes of meeting the needs of each resident. A review of rosters showed that a resident who was assessed as requiring 1:1 supports was now consistently receiving these. The provider also a plan in place to reduce the number of residents living in the centre over time and this would likely lead to less issues in relation to incompatibility and improve the lived experience of residents living in the centre.

There was evidence of goals being set as part of the person centred planning process. Goals were generally identified based on residents' assessed needs and preferences and there was evidence that some residents were being supported to achieve these goals. For example, some residents had attended concerts and one resident showed the inspector photographs of a recent outing that was documented as a goal in their plan.

However, some of the plans reviewed did not demonstrate ongoing progress or efforts to achieve goals that were being set. For example, one resident had a goal of attending swimming that had been identified in May 2024. While there was some evidence of review of this goal in August, there was no progress documented to demonstrate that active efforts were being made to support this resident to achieve this goal. This resident also had a documented goal to attend a local church to light a candle and there was no evidence of this being achieved despite the centre being located within walking distance to the local church and this resident reported as

enjoying activity in the community.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The person in charge had not fully ensured that staff had up to date knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour. Positive behaviour support plans for nine residents were reviewed. Plans in place used a traffic light system with clear guidance provided for staff to support residents in this area. Some plans required review to ensure that the information was fully up-to-date. For example some plans had not been updated to reflect changes that had occurred in residents' living arrangements. Some plans were also overdue review as per the review dates detailed on them.

Inspectors spoke to staff present in the centre during the inspection and found that they were familiar and aware of positive behaviour support plans in place. For example, one staff member told an inspector about specific information detailed in a residents' behaviour support plan and how they would support resident in line with their plan.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider was not fully protecting residents from all forms of abuse. Incompatibility of residents in some units was continuing to impact on the ability of management and staff to meet the assessed needs of these residents and contributing to increased safeguarding risks and ongoing safeguarding incidents were reported as occurring in the centre. It is acknowledged that the provider had made progress with a plan to change the living arrangements of some residents in the centre this did appear to be having a positive impact overall. However, at the time of this inspection, safeguarding plans in place to prevent peer-to-peer abuse were not effective in protecting residents at all times from abuse.

For example, in the twelve months previous to this inspection, thirty incidents of suspected or alleged abuse had been reported to the Chief Inspector. All of these were peer to peer incidents and included low and medium level incidents of physical, verbal and emotional abuse. While none of these were indicated as causing serious harm to any resident, one resident did express to inspectors that they did not feel fully safe in the centre and the incidents reported did indicate that there was ongoing impact to residents from people that they lived with.

Training records viewed showed that six staff working in the centre did not have up-to-date safeguarding training completed. Also, an intimate care plan viewed for a resident had not been reviewed as appropriate to ensure that it contained up-to-date guidance for staff.

Judgment: Not compliant

Regulation 9: Residents' rights

There were efforts to afford residents their rights in this centre. There was evidence that residents had access to advocacy services and evidence was viewed in residents' files that residents' consent was obtained about various matters. Interactions between staff and the residents they cared for were observed to be respectful in nature and residents were seen to be afforded choices in relation to when they got up and when they attended activities such as their day service. Residents moved about the campus freely. While inspectors were told that some improvements had been made in relation to community access, including improvements in staff consistency and transport available to residents, further improvements were required to ensure that all residents had equal and regular access to community facilities and activities. This is covered under Regulation 13.

Previous inspections of this centre had found that residents had little control over the people they lived with and this was impacting on their lived experiences. At the time of this inspection living arrangements remained unchanged and continued to impact on residents. However, it is acknowledged that since the previous inspection, the provider had put a long term plan in place to address this and some progress was seen with this plan.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 3 OSV-0003697

Inspection ID: MON-0045512

Date of inspection: 16/12/2024

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A staff training matrix is available in the centre. A delegated staff member reviews this training document weekly and informs staff of when they are due their training. For face to face practical training, the staff member informs management 3 months in advance so appropriate bookings can be made. The PIC reviews this training matrix monthly to ensure staff remain in date with their training. Staff are notified by management to complete training in a timely manner and face to face training booked for staff as required. All staff have now completed safeguarding training, 14/02/2025. The 10 staff members who require Positive Behaviour Support Training are booked into the next available dates on 08/04/2025, 10/06/2025, 09/09/2025 and 11/11/2025. The 5 staff overdue manual handling training are booked into the manual handling course on 07/03/2025. The 3 staff overdue fire training will have this completed by 28/02/2025.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A review of the Audits system was completed by PIC 07/01/2025. Following this review, a comprehensive system has been put in place. All the centre audits for the three houses	

are now kept centrally in one folder in the PICS office.
The PIC communicates to all staff what audits are due each month via a shared link that the PIC sends to all staff via email. The new reviewed Audit schedule is also accessed on this link and is printed and put in the front of the Audit folder.
The Audit Folder is sectioned into months and there is a list of what audits are to be completed in each section. The PIC completes a monthly oversight of the audits completed, and has put in place an accompanying audit finding record for each audit to capture the actions following each audit and the progress on these. All staff are aware of this new system in place that captures actions required and completed. All audits within the centre are up to date in line with the audit schedule.

A staff training matrix is available in the centre. A delegated staff member reviews this training document weekly and informs staff of when they are due their training. For face to face practical training, the staff member informs management 3 months in advance so appropriate bookings can be made. The PIC reviews this training matrix monthly to ensure staff remain in date with their training. Staff are notified by management to complete training in a timely manner and face to face training booked for staff as required.

The provider has assigned a dedicated Project Lead for De-Congregation within the organization for 1 year. PIC and PPIM are actively reviewing steps and progressing actions to support a de-congregation plan for PWS in CCN3.
PIC is in consultation with Social Worker who is supporting PIC with application process for PWS to go on the Social Housing List. This initiative will enable all PWS to express interest in a property using the Choice Based Letting Scheme with Cork City Council - online weekly. Three other PWS are currently being processed for this scheme. The plan is to register all PWS in CCN3 on the housing list where appropriate. In addition, the PPIM explores all other opportunities which arise within the organisation that may be suitable for the residents of this centre. 31/01/2027
One resident has been awarded a property by Cork City Council. Works are currently underway to bring this property up to standard to meet regulatory compliance. In addition, a recruitment campaign is in progress to build a team for the individual moving into the property. 30/06/2025

PIC is in the process of reviewing timetabling schedules for each house to ensure that all residents are afforded equal opportunities to access the community. The PIC will provide guidance to the staff to recognise how time can be utilized more effectively to afford more opportunities of individualised activities and will further capture the daily activation for each resident. The PIC has weekly meetings with the staff to discuss activities and goals that have been completed and those that are scheduled within the week. This allows further governance and oversight to ensure that all residents have the opportunity to access external and meaningful activities as per their will and preference.

All staff have access to the information required on the available activities taking place in the community which is printed and sent to each house. The PIC has added external community experiences and goal progression as a standing item at each staff meeting.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

PIC is in the process of reviewing timetabling schedules for each house to ensure that all residents are afforded equal opportunities to access the community. The PIC will provide guidance to the staff to recognise how time can be utilized more effectively to afford more opportunities of individualised activities and will further capture the daily activation for each resident. The PIC has weekly meetings with the staff to discuss activities and goals that have been completed and those that are scheduled within the week. This allows further governance and oversight to ensure that all residents have the opportunity to access external and meaningful activities as per their will and preference.

All staff have access to the information required on the available activities taking place in the community which is printed and sent to each house. The PIC has added external community experiences and goal progression as a standing item at each staff meeting.

The PIC has discussed the importance of positive risk taking with all staff during a staff meeting, this item will be discussed at all future staff meetings linked with the agenda item of activities within the community.

The resident has now commenced swimming sessions in the pool every Wednesday with staff support (18/02/2025). In addition, staff are exploring community pools in the locality for her to attend that will meet her physical needs. In relation to the residents wish to light a candle in the church, this goal was achieved on 06/09/2024 and is now a regular activity that she can do as per her will and preference. She now explores the local community with support from staff such as attending local cafes and shops on a regular basis

Regulation 17: Premises	Substantially Compliant

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

All items identified within the inspection- missing shower tile, rusting on bathroom fittings and black residue on shower seals and tiling have been reviewed by the maintenance department 19/02/2025 and all works will be completed by 30/04/2025.

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 has weekly meetings with the staff to discuss activities and goals that have been completed and those that are scheduled within the week. This allows further governance and oversight to ensure that all residents have the opportunity to access external and meaningful activities as per their will and preference.

All staff have access to the information required on the available activities taking place in the community which is printed and sent to each house. The PIC has added external community experiences and goal progression as a standing item at each staff meeting.

The PIC has discussed the importance of positive risk taking with all staff during a staff meeting, this item will be discussed at all future staff meetings linked with the agenda item of activities within the community.

The resident has now commenced swimming sessions in the pool every Wednesday with staff support (18/02/2025). In addition, staff are exploring community pools in the locality for her to attend that will meet her physical needs. In relation to the residents wish to light a candle in the church, this goal was achieved on 06/09/2024 and is now a regular activity that she can do as per her will and preference. She now explores the local community with support from staff such as attending local cafes and shops on a regular basis.

However, the provider acknowledges that this was not documented accordingly within the resident's personal plan. The PIC has discussed with all staff the importance of accurate and timely documentation. The PIC has a schedule to complete audits of the personal plans, including goal progression which will ensure oversight. This will also be discussed during the weekly meetings with staff to discuss activities planned for the week.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The 10 staff members who require Positive Behaviour Support Training are booked into the next available dates on 08/04/2025, 10/06/2025, 09/09/2025 and 11/11/2025. Changes to the living arrangements in the Positive Behaviour Support plan for a resident was completed on 18/12/2024.

All positive behavior support plans will be reviewed in the upcoming annual MDT scheduled for 27/02/2025 and any changes required will completed.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The provider has assigned a dedicated Project Lead for De-Congregation within the organization for 1 year. PIC and PPIM are actively reviewing steps and progressing actions to support a de-congregation plan for PWS in CCN3.
PIC is in consultation with Social Worker who is supporting PIC with application process for PWS to go on the Social Housing List. This initiative will enable all PWS to express interest in a property using the Choice Based Letting Scheme with Cork City Council - online weekly. Three other PWS are currently being processed for this scheme. The plan

is to register all PWS in CCN3 on the housing list where appropriate. In addition, the PPIM explores all other opportunities which arise within the organisation that may be suitable for the residents of this centre. 31/07/2027
One resident has been awarded a property by Cork City Council. Works are currently underway to bring this property up to standard to meet regulatory compliance. In addition, a recruitment campaign is in progress to build a team for the individual moving into the property. 30/06/2025

All staff have now completed safeguarding training, 14/02/2025.

Intimate care has been updated to ensure the correct guidance is available to staff, 17/12/2024.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The provider has assigned a dedicated Project Lead for De-Congregation within the organization for 1 year. PIC and PPIM are actively reviewing steps and progressing actions to support a de-congregation plan for PWS in CCN3.
PIC is in consultation with Social Worker who is supporting PIC with application process for PWS to go on the Social Housing List. This initiative will enable all PWS to express interest in a property using the Choice Based Letting Scheme with Cork City Council - online weekly. Three other PWS are currently being processed for this scheme. The plan is to register all PWS in CCN3 on the housing list where appropriate. In addition, the PPIM explores all other opportunities which arise within the organisation that may be suitable for the residents of this centre. 31/07/2027
One resident has been awarded a property by Cork City Council. Works are currently underway to bring this property up to standard to meet regulatory compliance. In addition, a recruitment campaign is in progress to build a team for the individual moving into the property. 30/06/2025

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/03/2025
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/03/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Not Compliant	Orange	11/11/2025

	as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2025
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/01/2027
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal	Substantially Compliant	Yellow	31/03/2025

	plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	11/11/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/01/2027
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	14/02/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice	Substantially Compliant	Yellow	31/07/2027

	and control in his or her daily life.			