

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003698
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Bernadette O'Sullivan
Lead inspector:	Aoife Fleming
Support inspector(s):	Mary Moore;Mary Costelloe;Sharron Austin;Maria Scally
Type of inspection	Unannounced
Number of residents on the date of inspection:	36
Number of vacancies on the date of inspection:	5

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
03 June 2015 08:15	03 June 2015 18:30
04 June 2015 08:15	04 June 2015 19:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This inspection was conducted to follow up on progress since the issuing of an Improvement Notice to the centre after the last inspection (March 2015). The centre consisted of eight houses with a maximum capacity of 41 residents. During the inspection, inspectors met with residents, staff members and staff. The inspectors met with the nominated provider to discuss actions taken since the Improvement Notice was issued. The premises and documentation were reviewed, and care practices were observed. Due to the complexity of their needs many residents required a high degree of support and assistance with their activities of daily living and individual care. However, the inspectors found strong evidence that demonstrated wholly insufficient changes had been made on foot of the Improvement Notice to improve their overall quality of life.

This inspection report covers fourteen outcomes. Inspectors found that there were

continued significant failings and non-compliances with the Regulations in this centre. These contraventions included core outcomes of governance and management, workforce, health and safety and risk management, residents' rights, dignity and consultation, safeguarding and safety and healthcare provision.

The key findings of failings and non-compliances in the centre are listed as follows:

- 34 of the 35 actions specified in the Improvement notice issued to the provider after the inspection in March 2015 had not adequately progressed:
- adequate safeguarding practices were not in place
- there was inconsistent and unsuitable management of restrictive practices
- staff were not appropriately managed, supervised or governed by management
- risk management and hazard identification and learning from sentinel incidents was inadequate
- the selection, provision and coordination of residents' activities was unstructured and did not adequately address individual residents' needs, preferences or goals.

By 19.00 on day two of the inspection, a total of four immediate action plans had been issued due to serious and significant failings found on this inspection:

1. Un-safe road vehicles (Outcome 7)
2. Suction machines, that were required by staff in the event of a resident choking, not working (Outcome 7)
3. Risk assessments for residents attending the on-site swimming pool were inadequate (Outcome 7). Following an adverse event in the swimming pool a Provider Led Investigation was requested by the Authority in relation to this incident.
4. An incident of alleged verbal abuse by a staff member towards a resident, was witnessed by inspectors and reported to the nominated provider (Outcome 8)

The response to these immediate action plans is outlined in the providers response to this report.

The nominated provider was put on notice that due to the consistent and serious failings identified over the course of three recent inspections, the Authority would be further escalating it's procedures regarding the regulation of this centre. Following the findings of this third inspection the nominated provider and Chief Executive Officer were requested to attend a meeting with the Authority.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There was no change in the compatibility of residents within houses since the last inspection. As was highlighted on the previous two inspections, and agreed by the provider in his response outlined in the previous inspection action plan , there was an urgent need to transition a resident to alternative accommodation The rights and dignity of this female resident were compromised by the behaviours that challenge of male residents in the house. However, no transition plan or timeframe was in place and staff were unsure of what action was to be taken to safeguard this residents privacy and dignity. There was no evidence that this resident had been consulted about decisions about her care. This resident was observed to be well on day one of inspection. However, on day two of the inspection the resident spent most of day, sitting in the dining room, without any activity in the house. An issue regarding the compatibility of residents in another house was also identified on the last inspection however, no action had been taken to discuss or develop a transition plan for this other resident. In addition, the behaviours that challenge of this resident continued to have a significant impact on the other residents in the house.

There was some improvement in terms of residents' exposure to a male resident who engaged in a disturbing and obsessive compulsive routine. The dignity of this male resident had been protected since the last inspection with screens used when necessary. There was a constructive and consistent effort from staff to protect the privacy and dignity of residents from certain behaviours. However, another resident was observed during the inspection displaying behaviours that challenge which compromised the privacy and dignity of other residents in the same house. Inspectors noted there were

no screens in place and staff reported that this behaviour occurred regularly. This resident did not have a suitable positive behavioural support plan in place to guide staff in the consistent management of his behaviour.

The inspectors did not see evidence of a meaningful, structured and improved activities timetable for residents to meet their interests or developmental goals. Residents were observed by inspectors spending long periods of time without activity and stimulation. Staff informed inspectors that management told them to organise the activities themselves; no extra training or guidance was provided. Inspectors met several staff who were now engaged in an activation role. However, these staff did not have a job description or additional training for this role, and there was no plan to guide the implementation of increased activities for residents. Staff informed inspectors that while the activation staff were in place to support resident recreational activities however, they could also be engaged in providing supervision at mealtimes, administering medication and managing residents with behaviours that challenge.

Inspectors saw that the activities recorded for one resident who did not engage in activities outside the house included television and one to one with staff. Music was also listed however, was only recorded as having been completed once in the month previous to this inspection. There were goals documented in the resident's care plan including 'having tea in the courtyard' and 'setting the table'. However, these were not listed on the activities chart or outlined to inspectors when staff were asked about residents activities. There was no evidence that this resident had been consulted about decisions about her care and support in relation to this transition plan.

In addition, the means of recording residents' activities was inconsistent. One resident had a progress sheet to record when the documented goal of 'drying his face' was completed. There was no progress sheet for the resident's goal of 'going out for a snack/beverage in the community'. On 7 days in May, there were no internal activities documented for this resident (the options were one to one with staff and television). In many residents activities sheets a 'spin' was listed as an activity. However, there was no detail regarding the spin in terms of outlining where the resident likes to go or what the goals of the spin were. One resident for example had only 5 spins in May and 7 spins in April. Many activities sheets were not dated; this was addressed in Outcome 18 Records. Overall, inspectors found that not all residents were supported or facilitated to participate in activities of their interest or to work towards achieving their goals.

An advocacy road-show was held in recent weeks however, residents who were non-verbal were not facilitated to attend. Staff in the centre were being trained as resident advocates. However, the benefit of a staff advocating for residents was questionable. This was in light of the significant and consistent failings in relation to safeguarding residents from abuse in this centre, including alleged verbal abuse incidents by staff towards residents on this inspection (see Outcome 8 Safeguarding & Safety) and the last inspection (March 2015). Inspectors were not made aware of any external or independent advocacy service available to residents. The risk register in one house stated that there was an advocacy committee in place. However, there have been no documented actions or records arising from these advocacy meetings.

The complaints logs were viewed by inspectors and a number of complaints had being documented since the last inspection. However, staff were using the complaints book to log maintenance issues; for example the suction machine that was not working was put

into the complaints log of one house. In addition, the outcome of complaints and the satisfaction of the complainant was not always documented.

Judgment:

Non Compliant - Major

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Staff were not appropriately trained to meet the communication needs of all residents. There was a resident in one house who used Lámh communication techniques. However, inspectors were told by two staff on duty in the house that neither had training in Lámh techniques to communicate with the resident on a day to day basis.

Staff showed inspectors what they called "communication passports". However, these were not adequate as they were a text based summary of individual residents' social profiles to support staff in knowing the residents. Inspectors noted that these communication passports did not detail the person centred support required for residents with communication difficulties.

The use of Picture Exchange Communication Systems (PECS) in the centre was inconsistent and not supportive of residents communication needs on a regular basis. In one house where a resident had been previously assessed for the use of PECS and tools were provided to support this however, the staff on duty could not outline to inspectors the use of these tools on a daily basis. In addition, the tools were not stored in an accessible location to facilitate their use.

Inspectors noted from communicating with residents and a review of residents' personal plans that the use of assistive technology to support residents in effective communication was not evident in the centre. There was a lack of detail in residents' personal plans to outline the different supports and communication needs of residents.

Judgment:

Non Compliant - Moderate

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Since the previous inspection, inspectors found that the provider had not changed the arrangements in place to support residents' contact and links with the wider community.

Inspectors did find that residents were supported to maintain links with their families with some visiting home for overnight stays. Inspectors also saw evidence of residents' phone calls with families and that staff contacted family members when necessary. Efforts had been made to maintain a visitors' room in a house where this room had previously been used as a storage room.

As was outlined in Outcome 1 Residents rights, dignity and consultation, not all residents were supported to develop and maintain links with the wider community. From communicating and observing residents, speaking to staff and management and a review of records inspectors formed the view that this was a resource and governance issue. Staff informed inspectors that the lack of availability of transport and lack of availability of staff to accompany residents on activities external to the centre was an ongoing issue which significantly impacted on residents' quality of life. The activities documented in residents' personal plans did not adequately highlight activities or goals for residents to participate in external to the centre.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors reviewed a sample of residents' personal plans and observed the residents day to day routines. Some residents had a detailed health check which assessed the residents' health care needs. However, a comprehensive assessment of residents social care needs had not been conducted for all residents. Evidence of multi-disciplinary input into residents' personal plans was not seen by inspectors. It was not possible to determine whether or not the residents participated in any assessment or discussion of their interests or preferences in relation to their social care needs as this was not documented for all residents. From speaking to residents, staff and a review of documentation, inspectors were unable to evaluate whether or not the activities in place for residents were based on their personal preference or not. For example, in relation to one particular resident, the only activities that were conducted in the house as per the documentation were television and staff one to one time. The external activities listed for this resident were spins, activation centre visits, multisensory room, karaoke and swimming. However, there was no evidence to support this choice of activities for the resident and the karaoke or multisensory room visits were not recorded as having occurred during the month of May. In addition, inspectors observed residents spending a significant amount of time without any purposeful activities and suitable stimulation. There was no documentation to support the progress around activities other than a tick box checklist to complete if the activity was conducted on a given day. Inspectors formed the view that since the last inspection the social care needs of the residents had not improved.

The provider informed inspectors that four new staff had been taken on as activation staff. However, as already outlined, without clear job descriptions, guidance or support from management, inspectors were not assured that this arrangement had improved the quality of life of residents. In addition, there was no evidence that the residents' access to technology and assistive devices had not improved since the last inspection.

Staff informed inspectors that the residents access to external activities, such as going for a spin or out for a meal or beverage, was regularly compromised due to the lack of availability of staff and transport.

One resident had been identified as been unsuitably placed in one house and urgently required alternative placement. The nominated provider informed inspectors that a transition was planned to move this resident from one house in the centre to another house. However, there was no documentation or transition plan in place to support staff or this resident with regard to the provision of life-skills for the new living arrangement.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Areas that had been addressed since the last inspection included:

- provision of new microwaves in the kitchens
- a more suitable lock had been put in place on the gate of one house
- wheelchairs and assisted chairs were stored in suitable locations.

Some of the actions from the last inspection were not addressed:

Not all areas of the premises were kept in good repair internally and externally. The enclosed gardens and courtyards of several houses were not maintained adequately, and were therefore inaccessible to residents. A grab rail and tiling beside a toilet were not securely attached to the wall and presented a risk of injury to residents. This had been highlighted on the previous inspection however, neither the grab rail or the tiling had been repaired. Not all areas of the premises were clean and suitably decorated, especially the kitchens which were seen to be visibly dirty. Not all areas of the premises were equipped, where required, with assistive technology, aids and appliances to support residents' capabilities and independence for example not all toilets and showers had grab rails.

The suction machine, for use by staff in the event of a resident choking in two houses was faulty. Another suction machine for use in two other houses had recently had a new tube fitted however, staff were unable to operate the machine in a timely manner which posed a risk to residents in the event of an emergency. An immediate action plan was issued regarding this, see Outcome 7 Health and Safety and Risk Management.

Staff and management told inspectors that the follow up of referrals to the maintenance department was often slow. As was outlined in Outcome 1, the complaints logs were being used inappropriately by staff to log maintenance issues.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily

implemented.

Findings:

Not all actions identified in the previous inspection were addressed; The centre had not implemented a robust system to identify, assess, manage and review risk on an on-going basis in the centre. Risks identified on the previous inspection had not been mitigated or addressed. In addition, new risks were also identified and these included;

- a press for storing cleaning agents and chemicals in a kitchen was unsecured
- there were no grab rails in place in some of the resident's toilets and showers
- loose tiles and a loose grab rail beside a toilet in one house had not been repaired since the last inspection

While a kitchen cleaning schedule logbook had been placed in each house since the last inspection however, staff told inspectors that the list of duties was not feasible given the current demands on their time to also provide resident care and support. Inspectors noted that kitchens were still dirty and that the floor covering was in need of repair in some places.

A sharps bin was stored in a press in the office of one house, and had to be moved each time residents' medical files needed to be accessed. This posed a risk of needle stick injury and cross-contamination.

Due to the serious and significant concerns identified by inspectors on this inspection three immediate action plans were issued to the provider regarding risks to resident safety in the centre:

1. One suction machine for use by staff in the event of a resident choking was not working and another suction machine was not fit for purpose as staff could not operate it in a timely manner. This was of particular concern as residents with documented high risks of choking and requiring staff supervision when eating and drinking were living in the centre.
2. The tyres on two of the resident transport buses were worn and bald and posed a risk to resident safety.
3. Individual risk assessments were not in place for residents who were going swimming. Some of these residents had identified significant needs including medical and physical needs for example epilepsy, falls risks and were dependent on staff for mobility.

There was documentary evidence that the provider had put in place centre-specific risk register dated 11/05/2015 which included the risks as identified in the regulations. However, on a day to day basis the risk register was not implemented in practice. For example the risk assessment around staffing issues in the risk register stated that staffing levels were currently a high risk issue. However, there were no controls or factors to mitigate this risk. In addition, other risks identified by inspectors, as outlined above, had not been included in the risk register.

Inspectors asked staff about the incident reporting and management system. Since April, staff had been instructed to record 'notifiable events to HIQA' in a designated logbook. On inspecting the log book in one house, inspectors found entries of injuries and bruises sustained by residents. However, it was not clear to inspectors who reviewed this information and how it was used to contribute to improvements to resident safety in the centre. There was no review of incidents or adverse events in the

centre and no feedback to staff regarding preventing future incidents was being conducted. In addition, there was no evidence of audits of the safety or of resident care in the centre. As is addressed under Outcome 14 Governance and Management, the annual review of the quality and safety of care in the centre did not adequately address risk or learning from incidents. The recommendations of the review did not include any actions to address, manage and control risks or learn from incidents and adverse events in the centre.

Inspectors reviewed the fire safety register in the centre and found that there was evidence of regular fire drills being conducted. Fire alarm systems were tested on a regular basis and daily inspections of fire escape routes were conducted by staff in the houses. Fire training had recently been provided for many staff members. However, there were still gaps in staff training. Since the last inspection individualised personal emergency evacuation plans had been developed for all residents.

However, overall, inspectors were not assured that hazard or risk identification in the centre, with appropriate controls, were being implemented in the centre and that this failing was having an adverse impact on resident safety in the centre.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

An immediate action plan was issued by inspectors to the provider in relation to safeguarding and safety. This action plan was issued following an incident of alleged verbal abuse witnessed by inspectors and perpetrated by a staff member towards a vulnerable resident. This incident was observed by inspectors on day two of the inspection and immediately brought to the attention of the nominated provider. This was the second such type of incident observed by inspectors as a similar incident occurred on the previous inspection where again an incident of alleged verbal abuse by staff was witnessed by inspectors. Therefore, inspectors had serious concerns that the

providers safeguarding plan following the last incident, and measures to protect residents from forms of abuse, were completely inadequate. The nominated provider reported this incident to the Authority as required. Staff training on safeguarding had been provided to most, however, not all staff, since the last inspection. Nevertheless, given the seriousness of these incidents and the inadequate safeguarding practices, inspectors formed the view that such training was not adequately protecting residents against abuse.

With regard to the investigation of incidents or allegations of abuse, inspectors were not assured that management were investigating, where appropriate, the incidents recorded in the 'notifiable events to HIQA' log book which was recently introduced. Incidents of residents' unexplained bruising had been recorded in some of these logbooks. This issue was also addressed under Outcome 7 Health and Safety and Risk management.

Inspectors had serious concerns regarding staff understanding and knowledge of behaviours that challenge. When staff were asked to describe residents, language such as 'non-compliant', 'unacceptable behaviour', 'in plain terms stubborn' was used. In many cases, a negative attitude towards residents' behaviours that challenge was demonstrated by staff. While many staff knew the residents very well, there was a disproportionate focus on their behaviours that challenge without addressing the positive behavioural supports required to improve their quality of life. Inspectors were concerned that a task oriented and institutional type attitude or approach regarding residents' behaviours that challenge may have led to a lack of suitable positive behavioural supports being put in place to identify and alleviate the cause of residents' behaviours that challenge.

Since the last inspection some positive behavioural support plans had been implemented in the centre. However, not all residents who required this type of plan had one developed and the implementation of such plans was inconsistent. In one case, the plan was implemented consistently by all staff to support one resident following specialist guidance. However, inspectors reviewed a sample of other residents' plans and found that the primary focus was on documenting the behaviour with little focus on identifying the antecedents or describing measures to alleviate the behaviour. Inspectors discussed the support plans with staff who did not see the purpose of the plan and were able to describe the residents in far more relevant detail than the plan conveyed. There was no documentation in place to indicate that these behavioural support plans had been discussed with the residents' families or next of kin where appropriate. From speaking to residents and staff, inspectors were not assured of the contribution of residents or their representatives to these behavioural support plans to improving residents' quality of life. For example, there was documentation in one residents' medical file of recent increases in behaviours that challenge and distress which had been referred to the psychiatrist for review. However, this was not reflected in the behavioural support plan nor was it documented in the resident's personal plan. No changes to the resident's daily routine or effort to identify or alleviate the causes of the behaviour were documented.

An inspector witnessed an incident of behaviours that challenge in one house whereby a resident became very physically and emotionally distressed. Before the incident a staff member had told the inspector that the resident was not in good form as a new staff member was working in the house that day and that it was important for this resident to feel comfortable and familiar with staff. This had been documented in the resident's

personal plan. When the incident occurred the new staff member was unable to assist. The inspector formed the view that while the cause of the resident's behaviours that challenge was known, the efforts to alleviate the resident's distress were inadequate, the staff induction to this house was not appropriate, and not all staff were trained to manage behaviours that challenge. This is also addressed under Outcome 17 Workforce.

Inspectors reviewed the practices around the use of restraint in the centre. Several actions had been identified in the last inspection regarding the use of restraint, however, these were not addressed in line with national policy and best practice. Inspectors were informed by staff that the restrictive practices review committee (RIRC) were undergoing a review of restraint in the centre. However, when referral documentation to the committee or resulting reviews were requested these documents were not provided to inspectors at any point during the two day inspection. Inspectors were told by staff that physical restraint was no longer used for example, for obtaining routine blood tests or cutting nails. However, inspectors noted that the documentation supporting this unsuitable practice was still in place in residents personal plans. Inspectors reviewed the personal plan and nursing notes of a resident where a groin harness was being used. As identified on previous inspections, this restraint was documented as primarily being used due to the residents' risk of falls, insufficient staff, unsuitable environment and the resident potentially hitting out at others. There was contradictory evidence from staff and management regarding the use of this restraint; management told inspectors that it was no longer in use. However, inspectors saw documentary evidence indicating its use on several occasions in May. Management were unsure whether or not it was used when the resident was attending the day centre. There was no updated guidance from the RIRC regarding the use of this restraint for this resident. There was no documentation guiding the restraint review and release. This practice was not in line with national policy or evidence based practice.

Practices around the use of bed-rails in the centre had improved since the last inspection and a day-time, as well as night-time, review and release checklist was implemented as bed rails were also used by day. The extra rail, which had previously posed a risk of entrapment, had been removed from the bed rail system. However, not all staff nurses were aware of a recent team meeting to review the use of the bed rails or of the implementation of a new bed rail assessment process.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

An incident of alleged verbal abuse by a staff member towards a resident which was witnessed by inspectors on day two of the inspection was immediately brought to the attention of the nominated provider and the required notification was submitted to the Authority within 3 working days as required.

A notification relating to an incident of a serious injury to a resident (Notification Form 3) was submitted to the Authority one working day prior to the inspection. However, the notification form did not contain adequate information to outline the seriousness of the incident. A detailed update on the incident was not provided to the inspectors when they were at the centre on day one of the inspection. The full details of the incident only became apparent to inspectors following a chance conversation between an inspector and a staff member during the afternoon of day one of the inspection.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The actions under this outcome were not satisfactorily addressed since the last inspection.

Inspectors reviewed a sample of residents' personal plans. The supports and documentation in place to ensure that residents received appropriate healthcare from specialists were inadequate. For example in one case, a residents bone scan appointment had been cancelled but the reason for cancellation did not outline in adequate detail the reason for cancellation.

Care plans did not adequately address the healthcare needs of residents. For example, one resident had a diagnosis of dementia, however, there was no care plan or supportive measures outlined in his personal plan to support him in this regard. When a staff nurse was asked to outline the residents healthcare needs, there was a focus on residents challenging behaviour and the diagnosis of dementia was not mentioned.

For several residents prescribed anti-epileptic medications that need regular blood level monitoring, there was no system in place to ensure that this was conducted when necessary. For example, one resident had these blood levels monitored over two years ago.

As was identified on the previous inspection, the inspectors that the access to health care information was difficult as information was kept in different locations in each house. This system did not facilitate communication between staff and healthcare professionals. This is addressed under Outcome 18 Records and documentation.

Since the last inspection, the system for the daily handover of information between staff at each shift change had changed. However, the new system did not include the healthcare attendants. Staff told inspectors that this compromised their ability to care for residents when they were not up date on their current healthcare needs. Also, in view of the inconsistent staffing arrangements in the centre, staff may be working with residents with whom they were unfamiliar without a detailed handover to guide the provision of care.

Inspectors were also concerned regarding the insufficient monitoring of a resident with a decreased appetite, increased requests for fluids and who had spent most of the days of inspection in bed. One nurse told inspectors that food monitoring diaries were not in place in the centre which was concerning considering this resident would regularly refuse meals and had eaten only one yoghurt up to 14.00 hours on day one of the inspection.

It was seen that some residents had their body weight monitored and documented in their personal plans. However, the body mass index was not calculated or recorded which is an essential step required to appropriately assess a resident's nutritional status. Residents who had experienced significant weight loss over time, for example one resident lost 5kg over two months, were not referred to a dietician for assessment. There was an overall lack of dietician input into residents care to ensure that their nutritional needs were being appropriately assessed and managed. This is of concern to inspectors as large quantities of nutritional supplements were seen in the centre with many residents being prescribed same.

Staff and management informed inspectors that access to allied health care professional services in the centre was poor. Several residents were observed receiving thickened fluids from staff. However, there was no speech and language therapist referral or assessment conducted or documented in their personal plans to guide this practice. Staff were asked about the use of thickening agents in fluids and varying answers were received, often not in line with evidence based practice and guidance for the use of these products. Several residents were observed by inspectors to have impaired mobility. However, occupational therapy and physiotherapy assessments were not always conducted to protect their mobility and safety.

Judgment:
Non Compliant - Major

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

While the actions from the last inspection were addressed, there were incidents of concern noted by the inspectors in relation to medication administration and documentation.

Inspectors reviewed the medication administration records for a resident with a diagnosis of epilepsy who was prescribed anti-epileptic medications. However, on the night after one seizure the resident had not been administered their 8 night-time medications which included 3 anti-epileptic medications. The following day the resident experienced another seizure. The note on the medication administration sheet to say that medications were not administered was not signed or dated by a staff member. When staff were asked about this by inspectors, the reason given was that the resident was asleep and staff did not want to wake the resident up. The resident's doctor was not contacted. The inspectors viewed the daily nursing narrative notes which were contradictory in that one note stated that the resident slept from 20.45 until midnight, however, another note stated that the resident slept from 20.45 to 7.00 the next morning. In view of the residents medical condition, inspectors formed the view that this was inappropriate withholding of medication.

In one residents medication administration sheet, a note was made on one medication when it was administered at a time different to that prescribed. However, the other medications for administration at the same time did not have the administration time amended, even though nurses informed inspectors that the administration time for these medications was also different to that prescribed. Inspectors formed the view that this documentation of medication administration was not in line with best practice guidance from An Bord Altranais Guidance to nurses and midwives on medication management July 2007.

Judgment:

Non Compliant - Major

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The actions from the previous inspection were not satisfactorily implemented.

The centre had a full time person in charge and the nominated provider was in contact regularly with the person in charge. However, inspectors found continued serious and significant inadequate governance arrangements in the centre. The nominated provider informed inspectors that since the last inspection, regular unannounced visits were made by him and the person in charge to the houses in the designated centre. However, the reports viewed by inspectors did not cover all the houses in the designated centre. The actions arising from these reports focussed primarily on environmental and physical issues such as cleaning in the centre and did not adequately address the incidents, accidents or risk identification in the centre. The residents' personal plans were not independently assessed by the provider nominee or person in charge during the visit. There was no assessment of the safety and quality of care and support provided in the centre or a plan in place to address any concerns regarding the standard of care and support.

The annual review of the quality and safety of care and support conducted by the provider nominee and the person in charge was conducted since the last inspection. However, inspectors found that the actions arising from the report were not specific and many were not implemented at the time of inspection. This was especially noteworthy with regard to incident management whereby policies and procedures to review and evaluate incidents were not in place. No evaluation or analysis of incidents in the centre had been conducted in order to assess the safety of care in the centre.

Despite the unannounced visits to some of the houses, inspectors were not assured of staff supervision by management. Inspectors spoke with many staff members during the course of the inspection. Inspectors formed the view that the provider had not facilitated staff to raise concerns about the quality and safety of the care and support provided to residents. Issues were usually raised to management verbally, according to staff, and there was no documentary evidence regarding issues raised. This inadequate arrangement also had a negative impact on the safety and suitability of the equipment and premises as maintenance issues did not receive timely follow up as outlined in Outcome 6 Safe and suitable premises and Outcome 7 Health and Safety and risk management. Inspectors requested the minutes of staff and management meetings however, these records were not produced. In recent weeks, the handover system which was conducted each morning was changed and healthcare assistants were no longer attending the handover meetings. Staff told inspectors that they had raised their

concerns verbally with management regarding this, but that they received no response.

Staff reported to inspectors that guidance and assistance from management was not supportive. Staff told inspectors that the new activation staff did not have a clear role description or plan from management as to how they were to implement the activity schedule in a structured and meaningful way.

The continued lack of adequate communication between staff and management, and the continued non-compliance with regard to ensuring the safety of residents in the centre resulted in inadequate governance and management of the centre. Overall, inspectors formed the view that inadequate governance had a significant and negative impact on the safety, welfare and quality of care for residents.

Judgment:
Non Compliant - Major

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors noted that adequate resources were not available to support the staffing requirements of the service to ensure the delivery of safe and effective care to all. Four new staff members had begun working in the centre, however, they were not appropriately managed as they had not received a job description or guidance from management of their roles and responsibilities. No extra training was provided to the activation staff to support them in their new role. There were inadequate arrangements in place to ensure that the kitchens in the eight houses were cleaned regularly and appropriately. This was also addressed in Outcomes 14 and 17. The lack of availability of transport and staff impacted on residents' quality of life, activities and links to the wider communities as also addressed under Outcomes 1 and 5.

Staff told inspectors that the follow up on maintenance requests took a long time and that many requests for repair of premises and equipment (e.g. suction machines) were regularly left outstanding. The nominated provider acknowledged to inspectors that there was difficulty ensuring follow up on maintenance requests. As was noted under Outcome 6 Safe and suitable premises and Outcome 7 Health and safety and risk management, there were several items highlighted for repair during the last inspection which had not been addressed.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Over the course of the inspection, inspectors noted that there continued to be inadequate staffing arrangements in place. Staff told inspectors that they were regularly moved between houses to cover on days where other staff were off on sick leave. Staff were taken from the activation centre to work in houses on a regular basis. On day one of the inspection, the activation staff from one house had to help with resident care in another house due to staff shortages. Inspectors were told by staff that there was not enough staff replacements to cover if a staff member was sick, and this sometimes resulted in staff members working on their own in houses with 5 or 6 residents. Staff told inspectors that while many staff were key-workers for individual residents, because of the inconsistent staff rota, they were often working in different houses and not spending enough time with the resident they were allocated. This had a negative impact on residents' welfare as there were several residents who required familiarity of staff as documented in their personal plans. Inspectors observed in two separate houses incidents where residents became visibly distressed when unfamiliar staff entered the house. However, in one of these houses a new staff member was working on the day in question and staff told the inspector that this was difficult for the resident. Inspectors formed the view that while this staff member had an induction to the designated centre however, this did not consider the impact on the resident. This was also addressed under Outcome 8 Safeguarding and Safety. Several staff members told inspectors of their frustration at the current staffing systems and lack of support and supervision and this had a negative impact on residents care. As already outlined in Outcome 14 Governance and Management, the healthcare assistants no longer attended the daily handover meetings which contributed to the lack of familiarity between staff and residents, especially if the staff were moved to a different house.

The nurse to resident ratio had not changed since the last inspection. There were three nurses to cover six houses in the clustered houses of the centre by day. By night, there were only two nurses on duty to cover the six houses. Nurses and staff told inspectors

that they were under pressure to fulfil their nursing duties and often had to rush their duties, such as conducting the medication round. Inspectors were not assured that the night time staffing levels and skill mix were sufficient to meet the needs and safety of the residents. Staff were also responsible for cleaning the kitchens every night and for cooking all residents meals at the weekends which they reported as being significantly time consuming and took them away from providing care or activities for residents.

The nominated provider informed inspectors that four new activation staff had been employed in the centre. However, as already outlined in this report such staff did not have a job description or a structured plan for their role and responsibility from management. Residents were still observed spending long periods of the day without meaningful activities.

Inspectors were not assured that the overall supervision of staff in the centre by management had improved since the last inspection. Given the aforementioned inconsistencies in staffing and the continued lack of clarity around roles and responsibilities, inspectors were not assured that residents received continuity of care and support to ensure that their individual needs were being met.

Regular staff training sessions had been conducted since the last inspection. However, not all staff had completed training relevant to their role in the centre. Some staff had not received training in the management of actual or potential aggression (MAPA), positive behavioural support and safeguarding residents even though they were caring for residents with multiple needs on a daily basis. Some staff working with residents with challenging behaviours told inspectors that they did not have the skills or training to manage these incidents without support from other staff. There were also gaps in fire safety training and manual handling. One staff member was not listed as trained or otherwise on most of the staff training records, therefore inspectors were not assured of what training they had received.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:

Many records that were viewed by inspectors were unsigned and undated, for example monthly activity checklists. In some houses, records such as residents' personal plans, medical notes and medication prescription and administration sheets were kept in multiple locations. This did not allow for ease of accessibility or availability of information for staff and health care professionals in the centre. In some cases, residents' files were stored in communal living spaces and were seen to be unsecured by inspectors in several instances which compromised residents' confidentiality.

There was inconsistent implementation of documentation across the centre as a whole. For example, new documentation or recording sheets were in place in some personal plans, along with the superseded sheets, which led to ambiguity in terms of which version to implement and adhere to e.g. the positive behavioural support documentation and health assessments.

Diligence around the storage of documentation was also an issue as the documentation in residents' personal plans were seen to be mixed up between residents on one occasion by an inspector.

In one residents' medication administration sheet, a note was made on one medication when it was administered at a time different to that prescribed. However, the other medications for administration at the same time did not have the administration time amended, even though nurses informed inspectors that the administration time for these medications was also different to that prescribed. Inspectors formed the view that this documentation of medication administration was not in line with best practice guidance. This was outlined under Outcome 12 Medication management and an action has been issued under this outcome relating to records and documentation.

Judgment:

Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Aoife Fleming
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Action Plan

Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003698
Date of Inspection:	03 June 2015
Date of response:	30 July 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The rights and dignity of a female resident were being compromised by the challenging behaviour of male residents in the house.

In another house, the challenging behaviour of one resident was impacting on the quality of life of other residents in the house.

1. Action Required:

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

Please state the actions you have taken or are planning to take:

1. Privacy screens are in place. These are now used to protect the privacy and dignity of residents during episodes of behaviours that challenge.
2. A review of the compatibility of residents is being conducted by the Person in Charge.
3. This review has been completed on six residents some of whom will be moving to a new residence together in August.
4. Any incompatibilities identified will be acted on either by the implementation of a safety plan and or a transition plan.
5. A review staffing is being undertaken and staffing has been initially increased prior to completion of same.
6. The Foundation is to undertake a fundamental review of service provision and supports in Ard the designated centre. It is apparent, that as a result of the serious non compliances identified by HIQA, that the model of service that is being employed in the designated centre is no longer fit for purpose and must be addressed with the ultimate goal being the reconfiguration and de-congregation of the designated centre.

Proposed Timescale:

1. In place since April 2015.
2. 31st August 2015.
3. Completed on 17th June 2015.
4. –
5. 31st August 2015
6. 11th September 2015

Proposed Timescale: 11/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no evidence that a resident had been consulted about decisions about her care and support in relation to the development of a transition plan.

2. Action Required:

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:

1. A review of the compatibility of residents is being conducted by the Person in Charge. The review will include:
 - A review of all incident reports for the last 18 months.

- Any examples of negative peer to peer interactions will be highlighted (for example: physical assaults, verbal assaults, residents' behaviour triggering a negative response in another resident, possible privacy and dignity issues).
 - A rights review for all residents will be conducted; the focus will be to determine whether any restrictive measures or risk control measures that are deemed necessary for a resident impact negatively on their or any other residents rights.
- 2.This review has been completed on six residents some of whom will be moving to a new residence together in August.
 - 3.Any incompatibilities identified will be acted on either by the implementation of a safety plan and or a transition plan.
 - 4.On completion of the compatibility review residents, their families and or representatives will be consulted regarding moving into accommodation with a compatible peer group
 - 5.Privacy screens are in place these are used to protect the privacy and dignity during episodes of behaviours that challenge.
 - 6.Additional multi-element behaviour support plans will be put in place as required.
 - 7.Personal safety plans will be put in place for those assessed as being at risk from their peers.
 - 8.A transition plan for the resident who has been assessed as being at risk from her peers been developed this resident is moving to another location on the 14th August 2015.

Proposed Timescale:

1. 31st August 2015
2. Completed 17th June 2015
5. Completed April 2015.
8. 14th August 2015.

Proposed Timescale: 31/08/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents who were non-verbal were excluded from a recent advocacy roadshow. Staff in the centre were being trained as resident advocates. Inspectors were not made aware of any external or independent advocacy service available to residents. The risk register in one house stated that there is an advocacy committee in place. As yet, there have been no documented actions arising from the advocacy meetings.

3. Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

Please state the actions you have taken or are planning to take:

- 1.An additional advocacy awareness work shop was held been for residents.
- 2.An advocacy champion is in place.
- 3.Identified staff are to undertake internal Advocacy Champion training.

4. Access to independent advocacy services has been arranged with the Cork Advocacy Service. Contact details will be prominently displayed and will be circulated to residents, their families and their representatives.
5. The independent advocacy service has also been approached to provide a visiting service whereby they would call to the service and talk to residents who wished to see them.
6. Minutes will be kept of all advocacy meetings. Setting out any actions arising and who is responsible for each action.
7. Information will be given to residents in relation to their rights in a variety of accessible formats.

Proposed Timescale: 28/07/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The quality of life, privacy and dignity of residents was negatively impacted on as they were exposed to the challenging behaviours displayed by other residents in their house.

4. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:

1. Privacy screens are in place. These are now used to protect the privacy and dignity of residents during episodes of behaviours that challenge.
2. A review of the compatibility of residents is being conducted by the Person in Charge.
3. This review has been completed on six residents some of whom will be moving to a new residence together in August.
4. Any incompatibilities identified will be acted on either by the implementation of a safety plan and or a transition plan.
5. Staffing has been initially increased prior to completion of staffing review

Proposed Timescale:

1. Completed April 2015
2. 31st August 2015.
3. Completed 17th June 2015
4. 1st September 2015.
5. Completed 1st June 2015.

Proposed Timescale: 01/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents were observed by inspectors spending long periods of time without activity and stimulation.

There was no evidence that this resident had been consulted about decisions about her care and support in relation to this transition plan.

5. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:

1. An interim programme of activities has been put in place for all residents.
2. A structured programme of activities will be put in place in line with the individuals assessed needs and wishes.
3. Residents will be consulted about their individual programme of activities.
4. During individual reviews residents will be consulted about the level of care and supports they require.
5. Individual structured plans will be drawn up which include the resources required to meet the plan.
6. Weekly reports by the activation staff detailing activities offered levels of participation and goals achieved will be reviewed by the Person in Charge and the Provider.

Proposed Timescale:

1. Completed 29th July 2015.
- 2-5. 31st August 2015.
6. Will be completed by 31st July 2015.

Proposed Timescale: 31/08/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents were not afforded the opportunity to participate in activities which met their interests and needs. The activities programme was unstructured and did not adequately address residents' developmental goals and interests.

6. Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:

1. An interim programme of activities has been put in place.
2. We have reviewed each individual's personal capacity to interact in activities as per their person centred plans.
3. A structured programme of activities will be put in place in line with the individuals

assessed needs and wishes.

4. Residents will be consulted about their individual programme of activities.

5. During individual reviews residents will be consulted about the level of care and supports they require.

Proposed Timescale: 31/08/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The provider failed to ensure that appropriate care and supports were in place to facilitate all residents to participate in activities to work towards achieving their development goals.

7. Action Required:

Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

Please state the actions you have taken or are planning to take:

1. The appropriate resources will be put in place to ensure that individual structured programme of activities for each resident will be facilitated.

2. The resources will be those identified as being necessary to complete the goals set out in the plans. These resources include but are not limited to staffing and transport. Transport is now being provided from a number of sources including the use of the centres vehicles, private hire arrangements and taxis.

3. Five additional staff have been employed since June 2015 to facilitate and plan activities which are in line with the residents assessed needs and wishes.

4. An additional 5 staff are also being employed to ensure continuity and support.

Proposed Timescale: 31/08/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Staff were not trained to meet the communication needs of the residents. The use of assistive tools and supports to facilitate resident communication was inadequate and inconsistent.

8. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:

- 1.Total Communication training has been completed by 20 staff. Further training to be planned for August 2015 – dates to be provided by trainer.
- 2.An audit of training has been conducted. The audit revealed a number of gaps where staff had missed training or required refresher training.
- 3.Any gaps in staff training have been identified and a plan will be put in place to address these.
- 4.Each resident will have their communication needs assessed / reviewed.
- 5.The appropriate assistive tools and supports will be put in place where a need is identified.
- 6.Detailed communication passports will be reviewed and completed for all residents.

Proposed Timescale:

- 1.31st August 2015
- 2.Completed 28th July 2015
- 3.7th August 2015
- 4.31st August 2015

Proposed Timescale: 31/08/2015

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all residents were supported to develop and maintain links with the wider community.

9. Action Required:

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:

- 1.All Personal Plans have been updated and individual goals identified.
- 2.The appropriate resources will be put in place to ensure that individual structured programme of activities for each resident will be facilitated. The resources will be those identified as being necessary to complete the goals set out in the plans.
- 3.These resources include but are not limited to staffing and transport. Transport is now being provided from a number of sources including the use of the centres vehicles, private hire arrangements and taxis.

Proposed Timescale: 30/08/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A comprehensive assessment of the social care needs of residents was not carried out.

10. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:

A comprehensive assessment of social care needs continues to be carried out by the relevant professionals.

Care Plans for 34 residents have been fully completed and involved consultation with the resident their families or representatives.

The details of these consultations have been recorded and signed.

These will include all or some of the following if relevant :

- OK health check
- Care plan template
- Barthel Index
- Supports Intensity Scale
- Malnutrition Universal Screening Scale
- Glasgow Epilepsy Outcome
- Scale
- Waterlow Pressure Sore Risk Assessment Tool.
- Individual Risk Assessment
- Risk Assessment for Behaviours of Concern
- Personal and Intimate Care Needs
- Pathways to Independence (Checklist of Self-Help Personal and Social Skills)
- DisDat Disability Distress Assessment Tool
- Bladder and Bowel Dysfunction Assessment
- Oral hygiene Assessment.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Arrangements were not in place to meet the assessed needs of residents with regard to activities and links to the wider community. The residents' access to technology and assistive devices had not improved since the last inspection.

11. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:

1. Five additional staff were appointed and commenced on the 1/6/15 – these additional staff are in place to support residents to ensure that activities are occurring consistently.
2. Sufficient resources will be put in place (including but not limited to transport, staffing, technology and assistive devices) to ensure that activities that are planned can go ahead.
3. An additional 5 wte are currently being recruited.
4. Weekly reports by the activation staff detailing activities offered, levels of participation and goals achieved will be reviewed by the Person in Charge.
5. The activation staff will receive individual supervision sessions once every 2 months with the Person in Charge

Proposed Timescale: 01/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The designated centre was not suitable for the purposes of the meeting the assessed needs of the residents. For example, external activities were compromised by the lack of availability of staff and transport to support residents leaving the centre.

12. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:

1. Five additional staff were appointed by the 1/6/15 – this additional staff are in place to support residents to ensure activities are occurring consistently.
2. It is also further increasing the allocation by another 7 WTE and recruiting of these staff has commenced.
3. While the recruitment of permanent staff is on-going agency staff are being put in place.
4. Sufficient transport is available to meet the needs highlighted in the individual structured programme of activities. Transport is being provided from a number of sources including the use of the centres vehicles, private hire arrangements and taxis.

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A comprehensive assessment of residents social care needs had not been conducted for all residents on at least an annual basis.

13. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:

A comprehensive assessment of social care needs continues to be carried out by the relevant professionals.

A date for annual review is included in each completed plan.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A comprehensive assessment of residents social care needs had not been conducted for all residents. Evidence of multi-disciplinary input into residents personal plans was not seen by inspectors.

14. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:

- 1.A comprehensive assessment of social care needs will be carried out by the relevant professionals.
- 2.If these professionals cannot be sourced from within the service they will be outsourced.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

It was not possible to determine whether or not the residents, or their representative, participated in any assessment of their interests or preferences of their social care needs as this was not documented for all residents.

15. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures 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.

Please state the actions you have taken or are planning to take:

1. A comprehensive assessment of care needs continue to be carried out by the relevant professionals.
2. These assessments involve consultation with the resident their families or representatives.
3. The details of these consultations are being recorded and signed

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The nominated provider informed inspectors that a transition was planned to move a resident from one house in the centre to another. However, there was no documentation or transition plan in place to support the staff or resident with regard to the provision of life-skills for the new living arrangement.

16. Action Required:

Under Regulation 25 (3) (b) you are required to: Provide support for residents as they transition between residential services or leave residential services, through the provision of training in the life-skills required for the new living arrangement.

Please state the actions you have taken or are planning to take:

A transition plan has been completed which includes details of the life skills required. The plan is in sufficient detail to guide the practice of staff in ensuring that needs are met in line with the residents needs and preferences. The plan included an assessment of the life-skills that would be required for the new service.

Proposed Timescale: 08/07/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The suction machine, for use by staff in the event of a resident choking in two houses was broken. Another suction machine for use in two other houses was not fit for purpose. The servicing and maintenance of these devices was inadequate.

17. Action Required:

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:

- 1.The suction machines have been repaired and a programme of servicing and maintenance put in place.
- 2.An additional suction machine has been provided.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all areas of the premises were kept in good repair internally and externally. For example, the outdoor area of one house had an uneven surface which posed a risk of falls. The enclosed gardens and courtyards of several houses were not adequately maintained, and were therefore inaccessible to residents.

18. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:

- 1.There is an on-going programme of remedial and maintenance work in place for the designated centre.
- 2.Detailed records are kept for the programme of works carried out in the centre for the 4 main maintenance contractors since February 1st 2015.
- 3.The status of each of the jobs indicates whether the job is completed or not and a completion date indicates the timescale.
- 4.The Provider and the Person in Charge check weekly or more regularly if required to ensure that works scheduled are completed.
- 5.All flooring issues have been surveyed by an external contractor and any faults rectified.
- 6.Loose tiles and loose grab rails have been repaired.
- 7.Enclosed court yards are now being maintained.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all areas of the premises were clean and suitably decorated, especially the kitchens.

19. Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:

- 1.A programme of deep cleaning and decoration has been put in place. Deep cleaning of the kitchens has been carried out by cleaning contractors.
- 2.The Person in Charge has revisited the cleaning schedule with the contract cleaners and has agreed a new schedule of cleaning of the kitchen areas.
- 3.The Person in Charge or the CNM1 will carry out hygiene audits weekly.
- 4.All flooring issues have been surveyed by an external contractor and any faults rectified.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all areas of the premises were equipped, where required, with assistive technology, aids and appliances to support residents capabilities and independence e.g. not all toilets and showers had grab rails.

20. Action Required:

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

Please state the actions you have taken or are planning to take:

- 1.A Facilities Management System called QFM has been implemented in Cope Foundation. This system allows staff (usually the manager or delegated person) to log maintenance issues as they arise. Each requisition is assigned a unique job number. The maintenance department rolls out the jobs to the relevant maintenance contractor and once completed the contractor changes the status of the job to reflect this on QFM. At all times during the cycle of work the manager/delegate, the maintenance department and the contractors can see the status of their logged jobs. This system allows for management of the maintenance issues and allows maintenance jobs to be prioritised, scheduled and monitored.
- 2.There is an on-going programme of remedial and maintenance work in place for the designated centre.
- 3.An OT has reviewed each bathroom and toilet area and has assessed the need or otherwise for grab rails etc.
- 4.These have been installed as per the OT recommendations.

Proposed Timescale: 30/07/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Risks identified on the previous inspection had not been mitigated or addressed and these included;

- a press for storing cleaning agents and chemicals in a kitchen was unlocked
- there were no grab rails in place in some of the resident's toilets and showers
- loose tiles and a loose grab rail beside a toilet in one house had not been repaired
- while a kitchen cleaning schedule logbook had been placed in each house since the last inspection, staff told inspectors that the list of duties was not feasible given the current demands on their time. Inspectors noted that kitchens were still dirty and that the floor covering was in need of repair in some places.

The hazard and risk identification procedures in the centre were inadequate.

21. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:

- 1.A full review of the risk register has been undertaken by the Provider and the Person in charge. Any issues that arose from the review have been acted on.
- 2.A full review of individualised risk assessments has been undertaken by the Provider and the Person in Charge. Any issues that arose from the review have been acted on.
- 3.An escalated risk register has been sent to and accepted by the Head of Division.
- 4.The Safety, Audit and Risk committee has been put in place and meet weekly.
- 5.There is an on-going programme of remedial and maintenance work in place for the designated centre.
- 6.A schedule of monthly meetings between the Person in Charge and Facilities Manager has been put in place.
- 7.Staff were briefed on safety and risk on the 24/7/15 by the Health and Safety Officer.
- 8.Any learning from above and feedback is given to staff by the CNM1 during supervision sessions and team meetings.
- 9.All incidents and accidents are formally reviewed by the Provider and PIC on a weekly basis and any learning from same is applied and communicated to staff and residents.
- 10.Any critical incidents will be reviewed in a timely fashion after the event.
- 11.All cleaning products are now suitably secured.
- 12.Faulty tiling and a loose grab rail have been repaired.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no review of the incidents in the centre and no feedback to staff regarding preventing future incidents was being conducted. There was no evidence of audits of the safety of residents or of resident care in the centre.

The systems for hazard and risk identification, control and management in the centre

were inadequate.

22. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

- 1.A full review of the risk register has been undertaken by the Provider and the Person in charge. Any issues that arose from the review have been acted on.
- 2.A full review of individualised risk assessments has been undertaken by the Provider and the Person in Charge. Any issues that arose from the review have been acted on.
- 3.An escalated risk register has been sent to and accepted by the Head of Division.
- 4.The Safety, Audit and Risk committee has been put in place and meet weekly.
- 5.There is an on-going programme of remedial and maintenance work in place for the designated centre.
- 6.A schedule of monthly meetings between the Person in Charge and Facilities Manager has been put in place.
- 7.Staff were briefed on safety and risk on the 24/7/15 by the Health and Safety Officer.
- 8.Any learning from above and feedback is given to staff by the CNM1 during supervision sessions and team meetings.
- 9.All incidents and accidents are formally reviewed by the Provider and PIC on a weekly basis and any learning from same is applied and communicated to staff and residents.
- 10.Any critical incidents will be reviewed in a timely fashion after the event.
- 11.The Chief Operating Officer reviewed the NF06 / 7 file in the Designated Centre and raised his concerns with the Provider Nominee and PIC about (a) the number of these forms being submitted and (b) the detrimental effect on people living in the Designated Centre as a result of what is being reported. This concern was heightened by the fact that many of them relate to peer to peer aggression that is on-going and being perpetrated by a small number of the people we support in the Designated Centre. The Chief Operating Officer requested that an immediate review of the NF06 / 7 submitted to HIQA since June 2015 be carried out and that a safety plan be put in place to manage the risks identified following this review.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The kitchens in the designated centre were visibly unclean in places and the implementation and supervision of the cleaning schedule was inadequate.

A sharps bin was stored in a press in the office of one house, and had to be moved each time residents medical files needed to be accessed. This posed a risk of needle stick injury and cross-contamination.

23. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a

healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:

- 1.The Person in Charge has revisited the cleaning schedule with the contract cleaners and has agreed a new schedule of cleaning of the kitchen areas.
- 2.The Person in Charge or the CNM1 will carry out hygiene audits weekly.
- 3.The importance of hygiene will be raised at all staff meetings.
- 4.All sharps bins are now stored appropriately.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all staff had up to date fire safety training.

24. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:

- 1.The four remaining staff that had not received training have now received fire training. This training included fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.
- 2.Basic fire training will be covered during on site staff induction, reminders will be given at team meetings.
- 3.Regular fire drills will be conducted.
- 4.A timetable for refresher fire training has been put in place.

Proposed Timescale: 30/07/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The provider failed to ensure that staff had up to date knowledge and skills, appropriate to their role, to respond to behaviour that was challenging and to support residents to manage their behaviour.

25. Action Required:

Under Regulation 07 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:

- 1.All staff will be trained in Multi element behaviour approaches.
- 2.Training to include the use of language used to describe behaviour and the use of positive behaviour supports.
- 3.MEBS training was provided to 49 staff further dates are scheduled for the remaining staff.
- 4.Behaviour support staff will provide guidance and training for staff in the implementation of individual behaviour support plans and individual safety plans

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no evidence in residents personal plans that, where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and reviewed as part of the personal planning process.

26. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:

- 1.Consultation and consent will be recorded in the behaviour support plan or care plan.
- 2.Comprehensive individual rights assessments will be completed where necessary and any infringements identified and acted upon.

Proposed Timescale: 30/07/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The provider failed to ensure that where restrictive procedures are used, they are applied in accordance with national policy and evidence based practice.

27. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

1. The PIC sought a review a review of the use of Restrictive Practices in The designated centre. This review was carried out by the Director of Development and Innovation and the Coordinator of Practice Development and Research.

The objectives of this review were to:

- Identify the scale of the use of restrictive practices in The Designated Centre .
- Identify the process used to put such practices in place.
- Ascertain staff's knowledge and understanding of restrictive practices and their implications for the lives of the people we support in The Designated Centre .
- Seek evidence of the right of individuals not to be restrained/ restricted being upheld.
- Offer support to the Management Team in The Designated Centre .
- Provide direction and recommendations to the CNM3 / PIC about changes to be made immediately and in the short term to ensure that the right to a restriction free environment for the people we support in The Designated Centre is maintained in as far as is possible.
- The following directions were given to the PIC in the report issued on 29th July 2015.
- Start to develop a culture in The designated centre from the premise that everyone should be allowed free movement.
- Prioritise people living their lives versus being managed.
- Look at providing alternatives in terms of activity to some clients e.g. Nintendo example.
- Instil in staff the idea that the use of restrictive practices is a conscious decision to interfere with an individual's rights and that same should only be considered in the most extreme and necessary cases.
- All staff must receive refresher training in the Restrictive Practices policy.
- Organise the immediate cessation of all chemical restraints that have not been administered during the last month.
- Carry out a complete review and audit of all chemical restraints and discontinue as appropriate.
- A detailed review must be undertaken of all Multi Element Behavioural Support Plans in the Designated Centre for evidence of restrictive practices being employed as reactive strategies.
- Ensure that where a restrictive practice has been identified in the MEBS / PCP or is being proposed, that all necessary risk assessments are carried out and documented.
- That a multi-disciplinary meeting be held to discuss each restrictive practice and debate its necessity and possible alternatives.
- No one individual should make a decision to put in place a restrictive practice. I.e. Behavioural Team member / S/N/ CNM.
- A Local Safety, Audit and Risk committee to be established. This committee should be responsible for approving the use of a restrictive practice on a case by case basis. This committee must ensure that all possible alternatives have been explored as per Cope Foundation policy and the least restrictive approach is being used. The committee will forward details of all restrictive practices being approved to the Foundation's Rights committee for oversight by them.

2. Training on the Restrictive Practices policy and HIQA guidelines on restraint procedures was provided to 60 staff. Further training is scheduled for August 12-27 2015.

3. MEBS training was provided to 49 staff further dates are scheduled for the remaining staff.
4. PRN medication was reviewed by the consultant psychiatrist.
5. A full review of all medications is commencing on 30th July 2015.
6. Protocols are in place to guide staff on the administration of PRN medication.
7. The alleged abusive interactions observed by the inspectors are being investigated.
8. The use of the groin strap detailed in the Report of the inspection which took place on 31st March and 1st April 2015 has been discontinued. The Restrictive Interventions Review Committee was informed of same by letter on 23/07/2015.
9. A Safeguarding Adults Risk Assessment & Risk Rating Tool has been developed to assess presenting risks indicating safeguarding concerns.
10. This Safeguarding Tool will be completed by PIC/PPIM in conjunction with staff where any possible infringement of residents' rights is highlighted or where safeguarding measures are deemed necessary.
11. A Local Safety, Audit and Risk Committee has been established.
12. A project group to put in place an organisation Rights Committee has been established. This committee will be responsible for the oversight and protection of individual's rights including oversight of the use of restrictive practices. The project group is currently drafting Terms of Reference and inviting external membership. This committee will be comprised of senior staff, people we support, family members and external members. In the interim the Restrictive practices committee will act as the rights committee.

Proposed Timescale:

1. Completed 29th June 2015
2. 31st August 2015
3. 31st August 2015
4. Completed 9th July 2015
5. 31st August 2015
6. Completed 30th July 2015
7. –
8. Completed 23rd July 2015
9. Completed 30th July 2015
11. Completed 15th July 2015

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The provider failed to ensure that every effort to identify and alleviate the cause of residents' behaviour was made; that all alternative measures were considered before a restrictive procedure was used; and that the least restrictive procedure, for the shortest duration necessary, was used.

28. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and

alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:

- 1.All staff will be trained in Multi element behaviour support approaches.
- 2.Training to include the use of language used to describe behaviour and the use of positive behaviour supports.
- 3.MEBS training was provided to 49 staff further dates are scheduled for the remaining staff.
- 4.Behaviour support staff will provide guidance and training for staff in the implementation of individual behaviour support plans and individual safety plans.
- 5.Onsite support for staff will also be provided by the Behaviour Support Team regarding any issues on completing recording sheets or difficulties implementing the behaviour support strategies.
- 6.Currently there are 30 behavioural support plans in place these were last reviewed in August 2014.
- 7.In future all individual plans will be completed using the Multi Element Support Plan format, which is more focused on proactive strategies designed to produce changes over time rather than being mainly focussed on reactive strategies.
- 8.The MEBS will be reviewed routinely at a minimum of 6 months, or as necessary, including quality of life issues to see if improvements have been achieved by comparison of assessments, baselines etc.
- 9.A total of 6 MEBS plans have been fully completed. The work on the remaining plans will continue and is due to be completed by the end of September 2015.

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

An incident of verbal abuse by a staff member towards a resident was witnessed by inspectors. The provider failed to ensure that all residents are sufficiently protected from all forms of abuse.

29. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:

- 1.A site specific safeguarding training was developed and delivered to staff.
- 2.Staff have received training in the National Safeguarding Vulnerable Adults Policy.
- 3.MEBS training was provided to 49 staff further dates are scheduled for the remaining staff. Training includes the use of language used to describe behaviour and the use of positive behaviour supports.
- 4.Behaviour support staff will provide guidance and training for staff in the implementation of individual behaviour support plans and individual safety plans.
- 5.A provider led investigation has commenced.

6. Staff are being reminded during team meetings about the use of appropriate language when talking to or about residents.

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff were recording some incidents in a 'notifiable events to HIQA' logbook, including unexplained bruising to residents. The provider failed to assure that allegations or incidents of abuse were appropriately investigated and acted upon, where appropriate.

30. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:

1. All incidents reports are now being reviewed and screened by the Person in Charge to highlight any protection issues.
2. Any protection issues identified will be screened / investigated and the appropriate safety plans put in place.
3. The logbook will be reviewed daily by the Person in Charge / PPIM or other designated person.
4. Staff have received training in how to complete the log book and how to report concerns.

Proposed Timescale: 30/07/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all staff had appropriate and up to date training in safeguarding residents and the prevention, detection and response to abuse.

31. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:

1. A site specific safeguarding training was developed and delivered to staff.
2. Staff will receive training in the National Safeguarding Vulnerable Adults Policy.
3. Reminders about the core issues will be given at team meetings and during individual supervision sessions.

Proposed Timescale: 14/08/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The full details regarding a recent incident were not submitted to the Authority on the notification form.

32. Action Required:

Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

Please state the actions you have taken or are planning to take:

1. Training will be given in relation to completing HIQA notification forms and the time scales required.
2. Emphasis will be placed on providing sufficient detail to fully describe the issue being reported.
3. The review of HIQA notifications will be standing agenda item for the weekly Person in Charge and Provider meeting.
4. The Person in Charge or the CNM1/ PPIM will carry out daily checks of log books.

Proposed Timescale: 31/08/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Appropriate health care had not been provided for each resident, having regard to each residents' personal plan.

33. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:

1. A comprehensive assessment of social care needs continues to be carried out by the relevant professionals.
2. Care Plans for 34 residents have been fully completed and involved consultation with the resident their families or representatives. The details of these consultations will be recorded and signed.

These will include all or some of the following if relevant :

- OK health check
- Care plan template
- Barthel Index
- Supports Intensity Scale
- Malnutrition Universal Screening Scale
- Glasgow Epilepsy Outcome Scale
- Waterlow Pressure Sore Risk Assessment Tool.
- Individual Risk Assessment
- Risk Assessment for Behaviours of Concern
- Personal and Intimate Care Needs
- Pathways to Independence (Checklist of Self-Help Personal and Social Skills)
- DisDat Disability Distress Assessment Tool
- Bladder and Bowel Dysfunction Assessment
- Oral hygiene Assessment.

3.Any needs identified will be met and the intervention required will be set out in a care plan.

4.The requirement for blood monitoring is guided and directed by GP and Consultant advice and will be documented in the residents medical notes.

Proposed Timescale: 30/07/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Residents referrals for specialist medical care were not always followed up on and insufficient documentation to explain this was not always in place.

34. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

Please state the actions you have taken or are planning to take:

- 1.Each resident will receive appropriate medical care and follow up.
- 2.The Person in Charge / PPIM will monitor this and detailed records will be retained of any medical issues identified.

Proposed Timescale: 30/07/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Overall access to allied health care professional services (speech and language therapy, dietician, physiotherapy) was poor in the centre.

35. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:

1. Where a resident requires access to an Allied Health Professional, this will be facilitated by the Person in Charge and the Provider.
2. If the relevant professional cannot be sourced from within the service they will be outsourced.

Proposed Timescale: 30/07/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was insufficient monitoring of a resident who was unwell with a decreased appetite, increased requests for fluids, who had spent most of the days of inspection in bed.

36. Action Required:

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:

1. Care plans will be put in place for any residents who are unwell
2. Food monitoring diaries – fluid intake records will be implemented where required.
3. Body mass index recording will be conducted monthly or more frequently if required.
4. Any residents who are unwell will be reviewed daily by the PIC / PPIM or their nominee and any changes required in care plans will be made or the appropriate specialist medical advice will be sought.

Proposed Timescale: 30/07/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

This is relation to the inappropriate withholding of anti-epileptic medication for a resident with epilepsy and the inaccurate documentation of medication administration.

37. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:

1. Medication audits are being carried out by the Person in Charge or the PPIM on a bi-monthly basis. Audits will look at whether appropriate and suitable practices are in place for the following:

- Ordering
- Receiving
- Prescribing
- Storing
- Disposal
- Administration

2. All medication errors will be followed up by the Person in Charge and reviewed by the Director of Nursing in line with Policy requirements.

Proposed Timescale: 30/07/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all staff had a job description to outline their specific roles and detailed responsibilities.

38. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:

We are proposing to address this by radically changing how Cork City North 4 is being managed and governed.

We undertook a full review of management and governance systems to ensure that they are sufficiently robust, in line with the requirements of the regulations.

Following this review and to address the management and governance issues cited by HIQA, Cope Foundation is implementing the following:

Key features and changes

- One location is currently in the process of being registered as a single designated centre. Submitted to HIQA – Cope Foundation has been informed that an application to

register this location is to be issued by HIQA at the end of August 2015.

- Cope Foundation is seeking to amend the registration of North Cork City 4 by registering the remaining settings as 6 separate designated centres
- Staffing will be allocated specifically to each designated centre.
- Two Shift Managers (CNM1s) to cover a cluster of 3 designated centres. Their responsibilities include the day to day care and support of the people living in each designated centre, handovers and good communication, staff supervision and performance management.
- There will be two Persons in Charge (PIC), one for each cluster of 3 designated centres. The Shift Managers will report to the PIC who is responsible for overall management and governance of the designated centres
- The Persons in Charge report to the Provider Nominee, who is a member of the Leadership Team who reports directly to the Chief Operating Officer
- The Chief Operating Officer reports to the Board of Directors.

Benefits

- Increased local management capacity i.e. an additional Person in Charge and 2 additional Shift Managers
- Increased capacity to focus on the specific needs of each person living in each designated centre and to support the implementation of each person's Person Centred Plan
- A structure to better to organise and support the diverse needs of people living in each designated centre
- Clear lines of accountability for work flow.

Cope Foundation has begun the process of applying to amend the Registration of Cork City (North) 4 into the new management and governance arrangements under section 52 of the Act for the variation or removal of any condition of registration attached by the chief inspector under section 50 of the Act.

Cope Foundation has also increased the management team supporting Cork City North 4 with the addition of 2 CNM1s and the appointment of a new PIC to support this arrangement in advance of approval from HIQA for these new arrangements.

Review

The Provider Nominee will review efficacy of the management and governance on a quarterly basis and will escalate any issues to the Chief Operating Officer and to the Board of Directors as required.

Job descriptions have been put in place for all staff, which outlines their specific roles and detailed responsibilities.

All job descriptions have been reviewed.

Proposed Timescale:

Review of management and governance arrangements completed 22nd July 2015.

Application to amend registration submitted 29th July 2015.

Additional CNM1s appointed 6th July 2015

Additional PIC appointed 27th July 2015

Proposed Timescale: 29/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The management systems in place in the designated centre failed to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

39. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

A full review of management and governance systems has been undertaken to ensure that they are sufficiently robust, in line with the requirements of the regulations.

Following this review and to address the management and governance issues cited by HIQA, Cope Foundation is implementing the following:

Key features and changes

- One area is currently in the process of being registered as a single designated centre. Submitted to HIQA – Cope Foundation has been informed that an application to register this area is to be issued by HIQA at the end of August 2015.
- Cope Foundation is seeking to amend the registration of North Cork City 4 by registering the remaining settings as 6 separate designated centres
- Staffing will be allocated specifically to each designated centre
- Two Shift Managers (CNM1s) to cover a cluster of 3 designated centres. Their responsibilities include the day to day care and support of the people living in each designated centre, handovers and good communication, staff supervision and performance management

There will be two Persons in Charge (PIC), one for each cluster of 3 designated centres. The Shift Managers will report to the PIC who is responsible for overall management and governance of the designated centres

- The Persons in Charge report in to the Provider Nominee, who is a member of the Leadership Team and reports directly to the Chief Operating Officer
- The Chief Operating Officer reports to the Board of Directors

Benefits

- Increased local management capacity i.e. an additional Person in Charge and 2 additional Shift Managers
- Increased capacity to focus on the specific needs of each person living in each designated centre and to support the implementation of each person's Person Centred Plan
- A structure to better to organise and support the diverse needs of people living in each designated centre
- Clear lines of accountability for work flow.

1. Cope Foundation has begun the process of applying to amend the Registration of Cork City (North) 4 into the new management and governance arrangements under

section 52 of the Act for the variation or removal of any condition of registration attached by the chief inspector under section 50 of the Act.

2.Cope Foundation has also increased the management team supporting the designated centre with the addition of 2 CNM1s and the appointment of a new PIC to support this arrangement.

Review

- The Provider Nominee will review efficacy of the management and governance on a quarterly basis and will escalate any issues to the Chief Operating Officer and to the Board of Directors as required.

Proposed Timescale:

Review of management and governance arrangements completed 22nd July 2015.

Application to amend registration submitted 29th July 2015.

Additional CNM1s appointed 6th July 2015

Additional PIC appointed 27th July 2015

Proposed Timescale: 29/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The annual review of the quality and safety of care conducted since the last inspection did not adequately address the safety of care, risk and incident management in the centre.

40. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:

1.A new audit tool has been sourced which will cover the following:

- The annual review template is based on the requirements of Regulation 23(1). It includes the core requirement of the regulation; notably that
- It is a review of the quality and safety of care and support in the centre
- It will test whether such care and support is in accordance with standards
- It will provide for consultation with residents and their representatives
- A copy will be made available to residents and, if requested, to the Chief Inspector
- It is a detailed tool; which has been sourced from The Wolfe Group, who designed the tool using 6 major areas for review (based on the national standards), notably
- Individualised supports and care
- Effective services
- Safe services
- Health and Development
- Responsive workforce
- Use of information

- The tool incorporates a process for seeking residents' views and a process for seeking views of residents' representatives.
- The tool incorporates a report template and an action plan template to address any deficits found in the standards of care.
- The action plan is based on a SMART approach to improving deficits; with clear accountability and dates for implementation of actions.

Proposed Timescale: 30/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The unannounced visits of the centre conducted by management failed to adequately address the quality and safety of care in the centre.

41. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:

- 1.A new audit tool has been sourced.
- 2.Six monthly provider assessments will be undertaken, utilising the new audit tool. Personal plans will be reviewed as part of these visits.
- 3.Programme of visits will be developed to ensure compliance with regulation 23(2).

Proposed Timescale:

- 1.Completed 30th July 2015
- 2.12th September 2015
- 3.14th August 2015

Proposed Timescale: 12/09/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Performance appraisals had not been conducted by management for all staff. Not all staff had a job description or clear guidance from management on their roles and responsibilities.

42. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements 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.

Please state the actions you have taken or are planning to take:

1. Performance appraisals will be held for all staff on an annual basis.
2. Job descriptions have been put in place for all staff, which outline their specific roles and detailed responsibilities

Proposed Timescale: 07/08/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no structured mechanism for staff to communication concerns or issues to management.

43. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:

1. All staff will receive one to one supervision sessions with management, based on a rolling schedule.
2. A standing item on the agenda for all staff meetings will be "concerns". Team meetings will be held every two months and all staff on duty will attend.
3. Minutes of Team Meetings will be made available to all staff will be required to read the minutes if they unable to attend the meeting.
4. The Person in Charge will review all team meeting minutes and take action as required.

Proposed Timescale: 30/09/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The provider failed to ensure that the centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

44. Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:

- 1.A staffing review has commenced and will be completed. The staffing review is to ensure there are sufficient resources to meet the requirements of regulation 15 (1).
"The registered provider shall ensure that the number, qualifications and skills mix is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.
- 2.Five additional staff were appointed by the 1/6/15 – this additional staff are in place to support residents to ensure activities are occurring consistently.
- 3.It is also further increasing the allocation by another 7 WTE and recruiting of these staff has commenced.
- 4.While the recruitment of permanent staff is on-going agency staff are being put in place.
- 5.Sufficient transport is available to meet the needs highlighted in the individual structured programme of activities. Transport is being provided from a number of sources including the use of the centres vehicles, private hire arrangements and taxis.
- 6.Where a resident requires access to an Allied Health Professional, this will be facilitated by the Person in Charge and the Provider.
- 7.If the relevant professional cannot be sourced from within the service they will be outsourced.
- 8.Resources have also been expended on additional relief staff, maintenance, consultancy and cleaning.

Proposed Timescale:

- 1.31st August 2015
2. Completed 1st June 2015
- 3&4. 21st August 2015
- 5.Completed 30th July 2015
- 6.Completed 30th July 2015
- 7.Completed 30th July 2015
- 8.Completed 30th July 2015

Proposed Timescale: 31/08/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The provider has continuously failed to ensure that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents.

45. Action Required:

Under Regulation 15 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:

- 1.A staffing review has commenced and will be completed. The staffing review is to ensure there are sufficient resources to meet the requirements of regulation 15 (1). "The registered provider shall ensure that the number, qualifications and skills mix is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.
- 2.Cope Foundation have increased the allocation of staff to the designated centre by 5 WTE (Activation staff since 1/06/15).
- 3.It is also further increasing the allocation by another 7 WTE while the review is taking place and the process of recruiting these staff has commenced. While the recruitment of permanent staff is on-going agency staff are being put in place.
- 4.Resources have also been expended on additional relief staff, maintenance, consultancy and cleaning.

Proposed Timescale:

- 1.31st August 2015
- 2.Completed 1st June 2015
- 3.21st August 2015
- 4.Completed 30th July 2015

Proposed Timescale: 31/08/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The provider has failed to ensure that the staffing arrangements ensure continuity of care and support for residents with regular changes to the staff rota which impacted negatively on residents quality of life.

46. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:

- 1.A staffing review has commenced and will be completed. The staffing review is to ensure there are sufficient resources to meet the requirements of regulation 15 (1). "The registered provider shall ensure that the number, qualifications and skills mix is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.
- 2.Cope Foundation have increased the allocation of staff to the designated centre by 5 WTE (Activation staff since 1/06/15).
- 3.It is also further increasing the allocation by another 7 WTE while the review is taking place and the process of recruiting these staff has commenced. While the recruitment of permanent staff is on-going agency staff are being put in place.
- 4.Resources have also been expended on additional relief staff, maintenance, consultancy and cleaning.

5.Guidelines have been developed and are being implemented with regard to the distribution and allocation of staff in the event of staff absence. The guidelines will ensure that continuity of care is provided where staff are required to move to work in a different house.

Proposed Timescale:

- 1.31st August 2015
- 2.Completed 1st June 2015
- 3.21st August 2015
- 4.Completed 30th July 2015
- 5.Completed 30th July 2015

Proposed Timescale: 31/08/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all staff have conducted the relevant training to meet the daily required needs of their roles.

47. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:

- 1.An audit of training has been conducted. The audit revealed a number of gaps where staff had missed training or required refresher training.
- 2.Any gaps in staff training have been identified and a plan will be put in place to address these.
- 3.Training plan will be put in place for each staff member following Performance Appraisals.

Proposed Timescale: 07/08/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff in the centre were not appropriately supervised.

48. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:

1. Individual supervision sessions will be provided for all staff.
2. Team meetings will take place bi-monthly for all staff.
3. Minutes of team meetings will be kept and any staff that misses meetings will be required to read the minutes.
4. Support will continue to be provided by behaviour specialist staff.

Proposed Timescale: 30/09/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Records regarding resident care were often unsigned and undated. Records were not always readily available to inspectors as they were stored in multiple locations and were not always secured.

49. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:

1. All records will be audited on a monthly basis by the PIC.
2. All unsigned and undated documents will be signed and retrospectively dated (where permissible).
3. Staff will be reminded during individual supervision sessions if they have failed to date or sign documents appropriately.
4. Records required to be kept in the designated centre will be stored securely in the designated centre.

Proposed Timescale: 31/08/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A amended record of medications administered to a resident at a time different to prescribed was not made to each medication involved, as required by Regulation 21 (1) (b), Schedule 3 (3) (h).

50. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:

- 1.All records will be audited on a monthly basis by the PIC.
- 2.All unsigned and undated documents will be signed and retrospectively dated (where permissible).
- 3.Staff will be reminded during individual supervision sessions if they have failed to date or sign documents appropriately.
- 4.Records required to be kept in the designated centre will be stored securely in the designated centre.
- 5.The actual time of administration of medication will be recorded in the medication administration record; in accordance with prescribing instructions.

Proposed Timescale: 31/08/2015