### Centre name:
A designated centre for people with disabilities operated by COPE Foundation

### Centre ID:
OSV-0003696

### Centre county:
Cork

### Type of centre:
Health Act 2004 Section 38 Arrangement

### Registered provider:
COPE Foundation

### Provider Nominee:
Colette Fitzgerald

### Lead inspector:
Mairead Harrington

### Support inspector(s):
John Greaney; Liam Strahan; Margaret O'Regan; Noelle Neville

### Type of inspection:
Announced

### Number of residents on the date of inspection:
17

### Number of vacancies on the date of inspection:
0
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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

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

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Summary of findings from this inspection

This centre, operated by COPE Foundation, was a designated centre providing accommodation and care for people with varying levels of intellectual and physical disability. This was an announced inspection, carried out over two days, for the purposes of informing a decision to register the designated centre.

As part of the inspection the inspectors met with residents, the nominated provider, the person in charge, relatives and other staff members. The inspectors reviewed the policies and procedures in the centre and examined documentation which covered issues such as staff training, complaints and advocacy, personal care plan.
development, staff training and health and safety risk management.

The findings of the inspection are set out under 18 Outcome statements. These Outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities Regulations 2013 and the associated National Standards.

Areas for improvement were identified in relation to documentation and the maintenance of centre specific policies, governance and staff training, and also premises and related risk management issues. Findings around fire safety management systems were such that an immediate action was issued to the provider. The provider responded promptly on this action and returned a report by a competent authority on the fire safety of one unit as requested. These areas are covered in greater detail in the body of this report.
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):
This was the centre’s first inspection by the Authority.

Findings:
The inspectors observed that staff interacted positively with residents, observing privacy and dignity in their day-to-day activities as a matter of course. Staff demonstrated a well-developed knowledge of residents’ needs and personalities and delivered appropriate levels of support. Inspectors noted that consultation processes were in place with some residents engaged informally on a one-to-one basis and a resident forum also in place in one unit. Where possible residents were involved in decision-making around day-to-day activities and also participated in the choice and preparation of meals. Residents were assigned key workers who acted on behalf of individual residents as evidenced in their personal plans of care. Advocacy arrangements were in place including access to an independent advocate. The designated centre provided a respite service and in many instances the rooms of existing residents were used to provide respite as required. However, this use of residents’ bedrooms for people accessing the service on a respite basis did not ensure each residents’ privacy and dignity was being respected.

A current copy of the organisational complaints policy was in place and a log of complaints was maintained with outcomes recorded. Personalised, easy-to-read booklets explaining the complaints procedure were available to each resident. Where the complaints procedure was on display it was in an easy-to-read format; however, it did not identify the complaints officer.

A policy was in place on the management of clients’ property and an inventory of belongings was seen to be maintained for each resident. Residents clearly had ownership and control over their own belongings and, where possible, also managed
small amounts of personal funds. There were appropriate arrangements in place for the management and safe keeping of day-to-day finances. Many residents were involved in the management of their finances with the support of families and staff. However, the policy on client property required development on protecting personal accounts and action in this regard is recorded against Outcome 18 on Documentation and Records.

Facilities in place to support recreation and activities varied between units depending on the needs and abilities of residents. The centre could access facilities in the area including those provided on the nearby main campus of the service, which included day services and a hydrotherapy pool, for example. However, in practice, access to these services was dependent on a number of variables such as availability, staffing and transport. Based on observations by inspectors throughout the inspection, and feedback from both relatives and staff, some residents were left without appropriate activation due to a lack of one or more of these resources. These findings are further detailed and covered for action under the related Outcomes 5 on Social Care, 16 on Resources and 17 on Staffing. Also, in one unit there were three two-seater sofas for six residents in a communal sitting room which did not facilitate or promote residents' independence or choice. Similarly, seating in the dining area of this unit could not accommodate all residents and staff at the one time, which again limited independence around residents' choice. Action in this regard is recorded at Outcome 6 on Premises.

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):
This was the centre’s first inspection by the Authority.

Findings:
A communication policy was in place and staff had a well developed awareness of the individual needs and habits of residents in relation to how they communicated their needs and expressed themselves. Where appropriate, communication strategies were in place that included folders of pictograms and photographs to assist residents in identifying people, locations, meal options and when participating in activities. Staff and several residents were also seen to use sign language effectively, including Lamh, which is Irish sign language. A policy on the provision of information to residents was in place. Personal care plans reviewed by the inspectors included information around the individual communication style and needs of residents and provided relevant advice and guidance to support staff in this regard. Assistive technologies were used in some instances with one resident using a tablet to support communication at day services.
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):
This was the centre’s first inspection by the Authority.

Findings:
The inspectors noted that staff and management at the centre supported positive relationships between residents and their families with many residents regularly returning home to their family for weekends and breaks. A visitors' policy was in place and visiting times were flexible. In some instances accommodation to receive visitors in private was limited and this issue is addressed under Outcome 6 on Premises. The inspectors reviewed feedback questionnaires from families and met with the relatives of several residents in the course of the inspection. This information indicated that family relationships were positive and supported and overall families expressed satisfaction with the quality of care delivered by the service. However, in some cases issues in relation to resources such as staffing and transport to support residents in their daily activation programme were identified. Action in this regard is addressed at Outcome 1. Also, issues around communication and consultation in relation to the delivery of care and achieving outcomes are further addressed at Outcome 5 on Social Care.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.
Findings:
There was a policy and procedures on admission, transfers and discharges which took account of the need to safeguard new and existing residents from potential peer-on-peer abuse in keeping with regulatory requirements. Admission criteria and practice reflected the terms in the statement of purpose. Residents' needs were assessed on admission and personal plans were developed in collaboration with residents which reflected areas such as personal goals, communication issues, personal care, activities and education and learning. Written contracts, signed by or on behalf of residents, were in place on individual personal care plans and included the terms of residence, services provided and any fees that might be applicable. However, in some instances dates were incomplete and in the case of one resident, while a contract was in place, it had not been signed by either the resident or a family representative.

Judgment:
Substantially Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
Each resident had a written personal care plan (PCP) which was well laid out and person centred with clear details around their individual needs and choices. Inspectors reviewed a number of PCPs which were comprehensive and personalised. These included records of residents' involvement and consultation where possible and included a nominated key-worker. However, in some instances relevant information, particularly in relation to the personal profile, was presented in a relatively technical format and was not easily accessible to the resident. Also, it was not always clear how these plans were being implemented to improve outcomes for residents, particularly around improving quality of life and realising goals. For example in some instances goals identified were not particularly meaningful or measureable such as "social community integration" and "provision of outings". Also, when reviewing residents' goal plans, the resources and responsibilities identified to achieve outcomes were often non-specific and simply referenced 'staff' or 'manager'. Goal plans were seen to be reviewed at regular milestones and many were seen to be achieved; however, some were not, particularly trips and outings. As outlined in Outcome 1, in many instances this was due to a lack of
resources including a limited access to transport and availability of staff to support residents on excursions. The centre had shared use of a vehicle with access after 5 pm and at weekends, where a sufficient number of appropriately qualified staff were available, there were outings and visits. Also, a dedicated transport vehicle collected residents who attended regular day services. However, this still left several residents in their unit for extended periods of times without effectively planned activities and therefore unsupported in developing meaningful or consistent expectations. Action on these issues is recorded against Outcomes 16 and 17 on Resources and Staffing. Personal care plans were regularly reviewed and inspectors noted that in some cases meetings were recorded where both staff and family members attended. However, consultation with families was not recorded in all of the PCPs reviewed and there was a lack of clarity around their involvement in agreeing goals. For example, where one resident required a specific dental hygiene programme, the family member spoken with by an inspector had had limited feedback from staff on this area of care, and review of a dental report dated 20 November 2015 indicated the care programme was not being implemented effectively.

Where the centre had access to transport facilities the inspectors saw that outings were provided including trips to the seaside and visits to a nearby wildlife park for example and, in the course of the inspection, residents were seen to being taken to services and inspectors saw residents being transported to and from a variety of activities and outings.

Judgment:  
Non Compliant - Moderate

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):  
This was the centre’s first inspection by the Authority.

Findings:  
This was a designated centre for adults with a disability. The centre comprised of three units, two of which were in close proximity to each other in a residential area of the north side of the city. The remaining unit was also located in a residential area approximately five kilometres away. On the days of this inspection the centre was home to 17 residents. The centre also provided a respite service for short breaks at all three units of the centre.

The first unit was a dormer bungalow accommodating seven residents. It was approached by a steep drive with space for parking several cars at the front. A separate
building was adjacent to the house and could be accessed from the rear of the unit. This building provided a communal space for residents and was used for activities such as arts and crafts. There was a porch area on entrance to the unit which led to a hall off which there was a communal sitting room, a dining room and a separate kitchen area. The premises was homely and nicely decorated with adequate seating and furniture available. A laundry area was located off the kitchen space which had secure storage for cleaning agents. Each resident had their own bedroom which was well laid out with ample storage that included lockable units. All were well decorated and personalised with photographs and belongings. There was a shower room and toilet on each floor. Facilities for the storage of supplies and equipment were adequate. The premises had suitable lighting, heating and ventilation. However, the inspector noted that a number of window frames were old and damaged and required replacing. This issue had also been identified as part of an environmental audit by management in March of this year. Otherwise, the premises were generally well maintained, furnished and decorated.

The second unit was a short distance from the first and comprised two semi-detached residential houses over two floors, between which access had been created to allow ease of movement within the living space of the premises. There was off-street parking at the front for several cars and a secure garden space at the rear. The premises comprised a small sitting room that could be used for visitors and a larger, communal sitting room with a TV. Seating in this room comprised three two-seater sofas and if more than three residents were in this space they had to share their seat. There was a dining area which could only seat six people at a time and staff explained that meals were usually in two sittings. There was a separate kitchen area with secure storage. However, tiling in the kitchen area was damaged leaving areas exposed. The unit accommodated six residents and each had their own bedroom, five on the first floor and one on the ground floor. All rooms had adequate storage and were personalised with individual belongings and photographs. A laundry area was located on the ground floor with a washer and separate dryer. There were two bathrooms, one on the ground floor, both provided adequate facilities including a shower, toilet and wash-hand basin. However, the equipment in the ground floor bathroom was in a deteriorated state and the room was cold and damp with mildew on the ceiling. Also, in one unit an exit used in the event of an emergency had a step and was not effectively accessible for a wheelchair user on that floor. Action in this regard is also recorded against Outcome 7 on Risk.

The third unit was several miles from the first unit and comprised two single storey, semi-detached residential houses that were laid out as one inside. This unit provided 24 hour nursing care to four residents with complex needs and mobility issues. The design and layout of the unit was in keeping with the statement of purpose and appropriate to meet the needs of the resident profile. Each resident had their own bedroom, which was appropriately equipped and furnished including adequate storage space. All rooms were personalised with photographs and individual belongings. The unit had a communal sitting area and also a sensory activity space with soft furnishings. There was an adequately equipped kitchen area with a dining table. Sanitary facilities were appropriate to the needs of residents and included assistive equipment.

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):**  
This was the centre’s first inspection by the Authority.

**Findings:**
A corporate safety statement was in place dated April 2014 which was overdue its annual review. Also, the risk management policy required review to reflect directions to staff in relation to site-specific procedures and also to outline the measures in place to address the specific risks identified in the regulations relating to missing persons, violence and aggression, self harm and accidental injury to residents, staff or visitors.

Inspectors noted that appropriate and effective infection control procedures were in place in each unit with hazardous substances securely stored and a colour-coded cleaning system in operation. A schedule of training in infection control was in place and appropriate hand hygiene practices and signage were in use. A health and safety committee operated at a regional level with a nominated health and safety officer identified at the centre.

Fire safety equipment such as extinguishers and fire blankets were readily accessible in all units and personal emergency evacuation plans were in place. Appropriate daily checks were undertaken and fire drills were conducted regularly and records of these activities were maintained. However, there were some omissions of times of drills and action in this regard is also recorded against Outcome 18 on documentation. Fire alarms in all units of the centre were serviced on a quarterly basis and equipment was serviced annually with emergency lighting also checked and certified.

Staff spoken with understood procedures for evacuation in the event of a fire or emergency. An emergency plan was in place and evacuation procedures and emergency contact details were displayed clearly in all units of the centre. However, in some instances these plans were not specific to the unit cited and, for example, referenced the restricted use of a lift where none was in place. A fire safety training programme was in place for all staff; however, refresher training due in October 2015 had not been completed for one member of staff.

The inspector saw that data was maintained and monitored in relation to incidents and accidents. However, the risk registers maintained in some of the units of the centre were generic and required further development as they did not reference site specific hazards relevant to the premises of that unit. For example, in one unit the use of an electric heater in a bathroom and the lack of a graduated step at a premises exit intended for use during emergency evacuations. This unit also had a downstairs fire
door held open at the time of inspection. In respect of these concerns an immediate action plan was issued to the service provider to obtain an assessment of this unit by a competent authority to ensure the implementation of effective fire safety management systems. This action was completed in a timely manner by the provider nominee and a report submitted to HIQA accordingly. Additionally, a fire survey report completed in June 2014 in relation to another unit had made recommendations which were not fully implemented such as the replacement of door leaves and a stair handrail.

An appropriately maintained vehicle was available to residents and an external audit system was operated to ensure that relevant maintenance processes and certification were in place and up to date. Designated drivers were licensed and had been appropriately vetted.

**Judgment:**
Non Compliant - Major

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**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
Measures to protect residents being harmed or suffering abuse were in place including a regular training programme and appropriate policies, which referenced relevant national guidelines. Security measures were in place with an attendance sheet and visitors’ log in use and staff demonstrated a vigilant attitude around the care and welfare of residents. A policy providing direction on the provision of intimate care was in place. Staff with whom the inspector spoke had received up-to-date training, understood what constituted abuse and were clear on lines of reporting and action to be taken. Where an allegation had been made procedures for managing the process were in line with relevant guidance and legislation. Documentation of the process was in keeping with statutory requirements.

There was a policy in place on the use of restrictive procedures including physical, chemical and environmental restraint. However, this policy referenced exemptions in relation to the definition of physical restraint which were not in keeping with national guidance and required review accordingly. Action on this finding is recorded against Outcome 18 on Records and Documentation. Instances where restraint was applied
were recorded and monitored in keeping with the relevant guidance and statutory requirements.

The inspectors noted that staff demonstrated a good understanding of the needs of residents and that interactions were attentive and responsive. There was up-to-date information in the residents' personal care plans in regard to the level of support required with their personal and intimate care needs.

A policy on the provision of behavioural support was in place, however, a member of staff in one unit had not had appropriate training in this regard. The circumstances of individual residents were taken into account and possible underlying factors were considered when developing strategies to provide behavioural support. Where specific behaviour plans were required these were developed with the input of an appropriately qualified healthcare professional.

**Judgment:**
Non Compliant - Moderate

### 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):**
This was the centre's first inspection by the Authority.

**Findings:**
An effective record of all incidents occurring at the centre was maintained and those incidents required to be formally notified in keeping with the regulations were submitted in a timely manner. Quarterly returns were also submitted as required.

**Judgment:**
Compliant

### Outcome 10. General Welfare and Development

_ Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition._

**Theme:**
Health and Development
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
There was a policy in place on education, training and development and it was evident from a review of personal care plans that residents were supported in accessing training and educational development appropriate to their assessed needs. No residents were in full-time education. Where residents had participated in training programmes and had received certificates these were on display in their rooms and sometimes elsewhere in the centre.

Judgment:
Compliant

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):
This was the centre’s first inspection by the Authority.

Findings:
The inspectors reviewed a number of residents' personal care plans (PCP's) across all units and found them to be of a good standard with person centred information and regular reviews and input by a general practitioner (GP) where necessary. In general, health needs were appropriately assessed and met by the care provided across the centre. This was based on discussion with staff and visitors and a review of documentation by inspectors. There was evidence of multi-disciplinary input on several PCP's reviewed. Based on a sample of records viewed by inspectors, residents were appropriately assessed using evidence-based tools for issues of risk such as falling and malnutrition. In two units residents had meals in a designated dining area and based on inspectors’ observations these experiences were a positive social event with assistance provided in a courteous manner by staff where necessary. Meal choices could be varied and personalised according to individual preferences and to this end pictograms and menu illustrations were used to good effect. Inspectors noted that food served was nutritious and snacks and drinks were also available and provided throughout the day. Inspectors noted that in one unit where dependency needs were high and some residents had specific swallow difficulties there was appropriate input by a speech and language therapist. In this unit staff were also appropriately trained to deliver support at mealtimes and specialist equipment was also available and appropriately maintained. However, one resident in this unit also required regular catheterisation and one member of staff was not appropriately trained to deliver this care. Action in this respect is recorded against Outcome 17 on Staffing.
Access to allied healthcare professionals was available with documented referrals in relation to consultations with dentists, dieticians and occupational therapists for example. A review of medical notes showed that a general practitioner (GP) was in regular attendance at all units across the centre. However, in one unit a review of one resident’s personal care plan indicated that there was inadequate follow through on a physiotherapist's recommendation for weekly access to hydrotherapy. Records indicated that access for this resident was not taking place on a weekly basis. In another unit referrals to a dietician had been made as a result of appropriate evidence-based assessments. However, where the documentation indicated that access to the community dietician was not available there was no evidence in the care plan of any proposed strategy to manage the welfare of the resident around these circumstances.

**Judgment:**
Non Compliant - Moderate

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**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
Written operational policies and procedures relating to the ordering, prescribing, storage and administration of medicines were in place and were supplemented by site-specific local protocols as directed by these policies. Inspectors observed the process of medication administration and noted practice was in keeping with national guidelines. Individual medication plans were in place and documentation included administration charts that corresponded to the prescription information and contained the necessary biographical detail for the relevant resident. Staff administering medication were appropriately trained. Systems for reviewing and monitoring safe medication management practices were in place. The person in charge implemented an effective audit system and took appropriate action, such as practice and training review, where needs were identified. Documentation on medication audits was available and last recorded in September 2015. The processes for handling of medicines were safe and in accordance with current guidelines and legislation with medications stored appropriately and securely. Appropriate arrangements were in place with the pharmacy service for the receipt and return of unused or out-of-date medicines.

**Judgment:**
Compliant
### Outcome 13: Statement of Purpose

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**

There was a written statement of purpose that accurately described the service that should be provided at the centre. The statement of purpose was comprehensive and contained all the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

**Judgment:**
Compliant

### 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 responsibility for the provision of the service.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
The governance arrangements for the centre being inspected were satisfactory with delivery of care directed via a designated person in charge who was suitably qualified and experienced and was employed on a full-time basis. The person in charge currently had responsibility for one additional centre in the region. The provider nominee also held responsibility for a number of other centres across the region. As identified in the relevant Outcomes throughout this report, issues were identified in providing social access to residents in relation to the availability of resources such as transport and suitably qualified staff. Action in this regard is recorded against the relevant Outcomes.
on Resources, Staffing and Social Care. Both the provider nominee and person in charge were aware of the constraints imposed on the delivery of service as a result of the limitations around these resources. The provider nominee was in regular attendance on-site and maintained ongoing contact with the person in charge. The provider nominee had also undertaken an unannounced visit to the centre in the previous six months and had completed an annual review on the safety and quality of care. However, this review related to specific, unannounced visits to the centre and did not adequately reflect an effective annual overview of management systems. In this respect it required further development to fully meet the requirements of the regulations.

Staff spoken with demonstrated a good knowledge of the standards and regulatory requirements and a copy of the National Standards for Residential Services for Children and Adults with Disabilities was available and accessible at the centre. Staff and management were found to be committed to providing quality, person-centred care to their residents. Governance was supported by effective systems of communication and supervision. Appropriate arrangements were in place for the deputisation of the person in charge. The person in charge had audit systems in place to ensure the delivery of a safe and appropriate service at this centre. However, measures to address issues identified by such audits and surveys, particularly in relation to premises and fire safety were not implemented in a timely manner - action in this regard is recorded against Outcomes 6 and 7 respectively. Audits completed in the previous six months included medication management, personal and intimate care, cleaning and the environment.

**Judgment:**
Non Compliant - Moderate

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**Outcome 15: Absence of the person in charge**
*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
There was no occasion when the person in charge was absent for a period that required notification to HIQA. There were adequate arrangements in place for when the person in charge is absent from the centre.

**Judgment:**
Compliant

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**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):
This was the centre’s first inspection by the Authority.

Findings:
The findings of this inspection indicated that adequate resources around staffing and transport were not always available to support residents in achieving their personal plans through social outings and attendance at activities outside the centre. Action on staffing is recorded against Outcome 17 on Workforce. Based on the inspectors’ observations, feedback from relatives and discussions with staff, it was identified that the lack of consistent access to an appropriate transport facility did not ensure the effective delivery of care and support to residents in keeping with the statement of purpose. These findings are further detailed at Outcome 5 on Social Care.

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):
This was the centre’s first inspection by the Authority.

Findings:
There was a centre-specific policy on recruitment and selection of staff. Recruitment and vetting procedures were robust and verified the qualifications, training and security backgrounds of all staff. Inspectors reviewed a number of staff personnel and training records and confirmed with both staff and management that performance management systems such as appraisals were in place and being implemented. Training records indicated that staff had access to appropriate training including manual handling, fire safety, safeguarding, first aid, hand hygiene and managing responsive behaviour. Records of staff files were maintained as outlined at Outcome 18 on Documentation and Records. A planned and actual staff roster was in use and properly maintained. At time of inspection there were no volunteers working for the centre.
The inspectors noted that, during interactions with residents, staff members were knowledgeable of their individual needs and provided assistance in a respectful, caring and timely manner. Staff spoken with were aware of, and understood, their statutory duties in relation to the general welfare and protection of residents. A copy of the regulations and Standards were available and accessible to staff. Staff were appropriately qualified and experienced to deliver care. However, based on the observations of inspectors and also discussions with staff and visitors, inspectors were not satisfied that there were sufficient staff numbers on duty at all times to meet the needs of residents. As described previously in this report, some residents could not go on outings unless there were enough staff rostered to support their needs, in this respect staffing levels were not always adequate to support the effective delivery of service around activation and social participation appropriate to the assessed needs of residents.

**Judgment:**
Non Compliant - Moderate

### 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):

This was the centre’s first inspection by the Authority.

### Findings:

Written policies and procedures, as listed in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons with Disabilities) Regulations 2013, were maintained and also readily accessible for reference. However, some policies required updating or review to reflect a centre specific approach. These included policies on risk management, restraint and client property. Findings in these areas are detailed accordingly against the relevant Outcomes in this report. Records in respect of Schedule 2 were maintained as detailed in outcome 17 on workforce. However, one file did not contain two references as required by the regulations.

A directory of residents was maintained and included the relevant information as required by Schedule 3 of the regulations, such as biographical information and the
contact details of specified parties. A residents’ guide which summarised the services and facilities provided by the centre and the terms and conditions of residency was also available.

Other records as specified in Schedule 4 of the regulations were available and accessible; these related to admission fees and services, the right and process of complaint, notifications and an effective risk register. Greater detail is provided on these areas under their respective Outcomes throughout this report. As recorded at Outcome 7, times for fire drills were not always recorded. The centre was appropriately insured and documentation to this effect was available dated 12 August 2015.

**Judgment:**
Non Compliant - Moderate

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**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:**

Mairead Harrington
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by COPE Foundation</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003696</td>
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<tr>
<td>Date of Inspection:</td>
<td>25 November 2015</td>
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<tr>
<td>Date of response:</td>
<td>25 February 2016</td>
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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 use of residents’ bedrooms for people accessing the service on a respite basis did not ensure each residents’ privacy and dignity was being respected.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:**
The provision of respite for people we support within Cork City North 2 is a vital resource to the individual and families. Within Cork City North 2 up to four respite places are available.

Written permission has been received to accommodate respite in residents’ bedrooms from their families. Any resident/family who decides that they do not want their bedrooms used for respite services will be accommodated.

In situations where a resident/family member has given permission for their room to be used for respite, the following procedures will be adhered to by all staff members:
- The individual’s personal possessions will be stored safely in their locked bedroom presses. The key is held in a safe place for them until their return.
- The room will be cleaned before the person availing of respite arrives and when they leave, i.e. the mattress on the bed and all hard surfaces will be disinfected. A copy of this cleaning schedule will be maintained.
- Separate bed linen is designated for use by residents on respite: i.e. separate duvets, sheets, pillows, duvet covers and pillow cases. Separate towels are also provided.
- Residents who avail of respite have their money stored in the safe for use whilst in residence. Receipts will be provided for all outgoings and co-signed by 2 staff members.
- Respite resident’s individual’s care plan accompanies them for all respite periods
- There is verbal and written communication between staff and families regarding the health and care needs of the person on respite.

The provision of personal and intimate care is supported by staff members where necessary and the privacy and dignity of the resident is maintained throughout. All staff members adhere to Cope Foundation’s Policy “Policies and Guidelines on Support People with Intellectual Disability and or Autism with Personal and Intimate Care”, an Easy Read Version of the Policy is available to all residents.

Due consideration is given to the compatibility of the full time residents and respite residents availing of respite as per Cope Foundation Policy “Policy and Guidelines – Safeguarding Adult we Support who may be unable to Protect themselves from Abuse”

In the future to ensure that each residents privacy and dignity is respected Cope Foundation is planning that all respite will be provided in designated respite centres across the organisation. In turn this will ensure that the practice of providing respite in full time resident’s bedrooms will cease. However this will take time as the additional resources required will have to be found. In Cork City North 2 any future requests for respite from families not already in receipt of respite will not be granted.

The PIC will ensure that all family members are aware of above procedures and are communicated in relation to any further changes, be it locally or organisationally in the area of allocation of respite.
The PIC will also ensure that all staff members are aware of and adhere to procedures as set out above through education and monitoring.

Proposed Timescale: 29-02-2016

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Proposed Timescale: 29/02/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints procedure on display did not identify a nominated complaints officer.

2. **Action Required:**
Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

**Please state the actions you have taken or are planning to take:**
The PIC has ensured that all complaints posters on display within Cork City North 2; now have the name and contact details of the Cope Foundation Complaints Officer. Within Cork City North 2 a site specific Easy Read complaints poster and relevant documentation will be developed to ensure that visitors and residents have access to information on the complaints procedure.

Proposed Timescale: 31/01/2016

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**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
In the case of one resident, while a contract was in place, it had not been signed by either the resident or a family representative.

3. **Action Required:**
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

**Please state the actions you have taken or are planning to take:**
The PIC to arrange a meeting with the resident’s family to discuss importance and relevance of contract of care. In the situation that this is not resolved a referral may be made to an independent advocate to ensure that the rights of the individual resident are met according to the regulations 24 (3)
### 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:**
In some instances personal profiles were presented in a relatively technical format which was not easily accessible to the resident.

**4. Action Required:**
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

**Please state the actions you have taken or are planning to take:**
The PIC will ensure that personal profiles are updated taking into account the intellectual ability of all residents. The aim is to ensure that the profile is individual to each resident’s needs, wants and aspirations. This will be carried through the following:
- Consultation with resident
- Consultation with family member
- Referral to Speech and Language Department to ensure that format utilised is unique to the individual and appropriate to their level of ability.

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### Proposed Timescale: 29/02/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
In some goal plans the supports required to achieve outcomes, such as resources and responsibilities, were vague and non-specific.

**5. Action Required:**
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

**Please state the actions you have taken or are planning to take:**
The PIC and staff members will review all Residents Personal Care Plans to ensure goals are identified, clear, and agreed in consultation with residents and families.

All Residents Personal Care Plans will:
- Have a named staff member responsible for supporting residents to achieve their identified personal goals.
- Resources required will be clearly identified.
• Access to resources will be set out in a clear and concise manner.
• Staff, family member(s) and individual’s responsibilities will be clear to all
• Evidence of consultation with resident
• Evidence of consultation with family member

Team Leaders in each location will work with the PIC to ensure that all goals are achievable and realistic. Team Leaders will take responsibility for ensuring that planning and goals are reviewed as required.

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

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

Review of a dental report dated 20 November 2015 indicated that arrangements were not in place to meet the assessed needs of a resident in relation to a dental hygiene care plan.

**6. 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:**
An updated Oral Hygiene Care Plan has been completed. This is now in place and being adhered to by all members of the team. The aim of this plan is to ensure that the assessed needs of the individual in relation to Oral Health are addressed and met. Dental report dated 20/11/2015 as developed by the residents dentist was utilised to ensure that all needs in relation to the area of Oral Health are addressed.

The PIC is to meet with family members to discuss updated Oral Hygiene Care Plan, and to ensure that they are in agreement with this current plan.

All staff working with this resident will attend a “Dental Care” refresher training presentation carried out by a HSE Dental Hygienist on the following dates: 29/01/2016, 03/02/2016 and 08/02/2016.

**Proposed Timescale:** 09/02/2016

**Theme:** Effective Services

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

Consultation with families was not recorded in all of the personal care plans reviewed and there was a lack of clarity around their involvement in agreeing goals.

**7. 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:**
The residents Personal Care Plans are currently under review by the team in Cork City North 2. The PIC and Team leaders in each location are organising a schedule of meetings with families to address the above identified requirement in full.

Staff members will ensure that any consultation with family members is documented clearly within Personal Plans.

PIC and Team Leaders will liaise with family members as to the importance of consultation in all areas of resident care including documentation and Personal Care Plans.

**Proposed Timescale:** 31/03/2016

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

In the first unit a number of window frames were old and damaged and required replacing.

**8. 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:**
A quote for works will be obtained by Cope Foundation. An application will be made to the HSE for funding to complete.

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

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

In the second unit tiling in the kitchen area was damaged leaving areas exposed.

**9. 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:
The PIC met with facilities manager and provider nominee on the 22/01/2016 to discuss action plan required under Regulation 17 (1) (b). Tiling in kitchen area will be replaced

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In the second unit equipment in the ground floor bathroom was in a deteriorated state and there was mildew on the ceiling.

10. **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:
The PIC met with facilities manager and provider nominee on the 22/01/2016 to discuss action plan required under Regulation 17 (1) (b).
Work completed includes:
• New extractor fan installed to the bathroom area on the 22/01/2016.
• Painting work carried out on ceiling area on the 22/01/2016.
Remaining work which is required to be carried out is:
• Current shower chair will be removed and new shower chair will be provided

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In one unit the seating arrangements in both the communal TV area and the dining area did not facilitate or promote residents' independence or choice.

11. **Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
The PIC to reiterate to all staff members in this location the importance of the use of both communal rooms in facilitating all resident’s independence and choice.

Each communal room has access to DVD player, TV, music system, comfortable seating and alternative relaxation resources e.g. newspapers, magazines. It is a personal
choice of some resident’s not to access the communal rooms if they see other resident’s utilising the space and utilise their private bedrooms, or other communal spaces within the house.

In this location we operate two sittings for meals and residents are encouraged and supported to exercise choice about which sitting they would like their meals. At weekends some residents go home, which reduces the number in this house and there is one sitting for meals if residents wish. Residents are also supported to avail of the opportunity to eat out within the local community.

In the event residents choose to sit together at one sitting, the dining table accommodates six individuals, on these infrequent occasions’ staff members use alternative seating provided in the kitchen. The PIC will ensure the Team Leader in this unit continues to review these practices, taking into account the changing needs of residents.

**Proposed Timescale:** 25/01/2016

**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:**
The risk management policy required review to reflect directions to staff in relation to site-specific procedures and also to outline the measures in place to address the specific risks identified in the regulations relating to missing persons.

12. **Action Required:**
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

**Please state the actions you have taken or are planning to take:**
Cope Foundation has a framework document which enables local managers to develop site specific local procedures, in conjunction with the Corporate Risk Management Policy and Safety Statement.

The current risk register in this designated centre will be strengthened and updated by the PIC in consultation with the Safety Officer, specifically in relation to missing persons using the Cope Foundation “Policy and Procedure on Missing Persons”.

The PIC will ensure that all staff are aware of Policy and Procedures both locally and organisational and adhere to same, individualised risk assessments and site specific guidelines will regularly be reviewed by PIC and team leaders.
Proposed Timescale: 31/03/2016
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy required review to reflect directions to staff in relation to site-specific procedures and also to outline the measures in place to address the specific risks identified in the regulations relating to accidental injury to residents, visitors or staff.

13. **Action Required:**
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
Cope Foundation has a framework document which enables local managers to develop site specific local procedures, in conjunction with the Corporate Risk Management Policy and Safety Statement.

The current risk register in this designated centre will be strengthened and updated by the PIC in consultation with the Safety Officer, specifically in relation to accidental injury.

The PIC will ensure that all staff are aware of Policy and Procedures both locally and organisational and adhere to same, individualised risk assessments and site specific guidelines will regularly be reviewed by PIC and team leaders.

Proposed Timescale: 31/03/2016
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy required review to reflect directions to staff in relation to site-specific procedures and also to outline the measures in place to address the specific risks identified in the regulations relating to violence and aggression.

14. **Action Required:**
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
Cope Foundation has a framework document which enables local managers to develop site specific local procedures, in conjunction with the Corporate Risk Management Policy and Safety Statement.

The current risk register in this designated centre will be strengthened and updated by
the PIC in consultation with the Safety Officer, specifically in relation to responding to incidents of aggression or violence.

The PIC will ensure that all staff are aware of Policy and Procedures both locally and organisational and adhere to same, individualised risk assessments and site specific guidelines will regularly be reviewed by PIC and team leaders.

**Proposed Timescale:** 31/03/2016  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The risk management policy required review to reflect directions to staff in relation to site-specific procedures and also to outline the measures in place to address the specific risks identified in the regulations relating to self harm.

15. **Action Required:**  
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

**Please state the actions you have taken or are planning to take:**  
Cope Foundation has a framework document which enables local managers to develop site specific local procedures, in conjunction with the Corporate Risk Management Policy and Safety Statement.

The current risk register in this designated centre will be strengthened and updated by the PIC in consultation with the Safety Officer, specifically in relation to self-injurious behaviour.

The PIC will ensure that all staff are aware of Policy and Procedures both locally and organisational and adhere to same, individualised risk assessments and site specific guidelines will regularly be reviewed by PIC and team leaders.

**Proposed Timescale:** 31/03/2016  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
In some instances evacuation plans were not specific to the residential unit and referenced the restricted use of a lift where none was in place.

16. **Action Required:**  
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.
**Please state the actions you have taken or are planning to take:**
The PIC has ensured Site Specific evacuation plans now in place. The PIC has met with staff in designated centre to ensure that they are aware of updated evacuation plan.

The PIC has contacted Communications department to ensure that easy read poster is updated and relevant to designated centre

**Proposed Timescale:** 31/01/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
In one instance a member of staff was overdue refresher fire training.

17. **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:**
The staff member identified is currently on leave and has been since training requirements were due. The PIC will ensure that fire training is completed upon their expected return to duty date.

**Proposed Timescale:** 30/04/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The registered provider did not ensure effective fire safety management systems were in place in one unit, in respect of these concerns an immediate action was issued to the service provider to obtain an assessment of this unit by a competent authority to ensure the implementation of effective fire safety management systems.

18. **Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**
An assessment has been completed by a competent fire engineer and a report has been received. The assessment by the engineer includes recommendations for replacement of fire doors and closing of seals and vents. It is estimated that a budget of €10K is needed to complete these works.
Cope Foundation will prepare a Business Case to the HSE for the funds to undertake the recommended works in the Engineers Report. The application will be made by end of March 2016. We are unable to advise when the HSE will give their response to this request. However if approval was given it is proposed that the associated works would take a month to complete.

This matter has been advised separately to the relevant personnel in HSE.

Proposed Timescale: Contingent on HSE response

**Proposed Timescale:**

**Theme:** Effective Services

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

The recommendations of a fire survey report from June 2014 in respect of one unit had not been fully implemented.

**19. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

An assessment has been completed by a competent fire engineer and a report has been received. The assessment by the engineer includes recommendations for improved containment in the event of fire, this include for replacement of fire doors and closing of seals and vents. It is estimated that a budget of €35K is needed to complete these works.

Cope Foundation will prepare a Business Case to the HSE for the funds to undertake the recommended works in the Engineers Report. The application will be made by end of March 2016. We are unable to advise when the HSE will give their response to this request. However if approval was given it is proposed that the associated works would take approximately 3 months to complete.

This matter has been advised separately to the relevant personnel in HSE.

Proposed Timescale: Contingent on HSE decision.
In one unit an exit used in the event of an emergency had a step and was not effectively accessible for a wheelchair user.

20. **Action Required:**
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
The provision of a suitable ramp for wheelchair users is to be provided.

**Proposed Timescale:** 31/03/2016

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**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:
In one unit one member of staff did not have appropriate training in managing responsive behaviours.

21. **Action Required:**
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

**Please state the actions you have taken or are planning to take:**
The one staff member without appropriate training is booked on the next available course which is the 11th and 12th February 2016.

**Proposed Timescale:** 13/02/2016

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In some instances access to healthcare professionals such as a dietician, or recommended therapies such as hydrotherapy, were not always available.

22. **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:**
PIC met Residents Day Service and relevant members of the MDT on 11/01/2016 to address the lack of access to hydrotherapy sessions as recommended by physiotherapist. Agreed schedule of access to hydrotherapy sessions will commence on 26/01/2016. Due to resource issues for accessing internal dietician services referrals are being forwarded to external services in consultation and agreement with residents families. PIC and Team Leaders will ensure all referrals will be promptly followed up and acted upon in a timely manner.

Proposed Timescale: on-going

**Proposed Timescale: 25/01/2016**

### 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:**
The annual report required development to fully meet the requirements of the regulations in relation to providing an effective overview of management systems on an annual basis.

**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:**
An Annual Review is scheduled to take place in the following 3 months in Cork City North 2.

Cope Foundation provided a training programme recently to senior personnel to carry out these reviews. This will ensure that Annual Reviews take place in all areas to meet HIQA regulations.

**Proposed Timescale: 31/03/2016**

### 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 lack of consistent access to an appropriate transport facility did not ensure the effective delivery of care and support to meet the needs of residents to achieve their individual personal plans.
24. **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:**
All houses within designated centre Cork City North 2 are located in close proximity to local bus routes. PIC will ensure that bus timetables are available for staff to increase usage of this local community resource. During the day some houses have a reduced number of residents, the team leaders in these houses will encourage increased use of public transport to go on outings.

Risk assessments will be carried out for use of public transport and all residents who are entitled use travel passes will be kept up to date by staff members. Residents can utilise their own funds to avail of local taxi service if going on social outing.

PIC will discuss the use of Cope Foundation vehicles with Transport Manager and Quality Systems and Shared Services Manager to increase access for residents to meet their personal goals. PIC will also discuss the funding of a D1 licence for staff members.

Staff will be encouraged to apply for permission to drive Cope Foundation vehicles through support and encouragement from PIC and Team Leaders. Family members are at all times encouraged to participate in activation for all residents in Cork City North 2.

**Proposed Timescale:** 31/03/2016

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staffing levels were not always adequate to support the effective delivery of service around activation and social participation appropriate to the assessed needs of residents.

25. **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:**
A review of current staffing levels allocated to Cork City North 2 will be completed with Provider Nominee to ensure appropriate support levels are in place.

In addition:
• PIC will apply to Volunteer Co-ordinator to assist in recruitment of a person specifically to assist in the activation of residents.
• Intellectual Disability Nursing Students are now availing of supervised placements in some locations in Cork City North 2 as part of the BSc (ID).
• FETAC Level 5 and 6 students now availing of learning placement in Designated Centre. These placements are organised in conjunction with PIC, Team Leaders and Volunteer Co-ordinator to ensure suitability of person to placement.

**Proposed Timescale:** 31/03/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Where the needs of a resident in one unit required staff trained in catheterisation, one member of staff was not appropriately trained to deliver this care.

**26. 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:**
Staff member is to undertake training in catheterisation on 27/01/2016.

The PIC will ensure that in the future any new member of staff has relevant training needs met before they report to their allocation to Cork City North 2

**Proposed Timescale:** 28/01/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Times for fire drills were not always recorded.

**27. Action Required:**
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
PIC met with staff members in Cork City North 2 to re-state their responsibilities in completing documents. This included:
• Time of fire drill
• Length of fire drill
• Any issues or concerns in relation to fire drill
• Any maintenance requirements etc.
Written guidelines and directions are in place for all staff.

PIC and Team Leaders will carry out spot checks to ensure this recommendation is complied with.

**Proposed Timescale:** 25/01/2016

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
One file did not contain two written references as required by Schedule 2 of the regulations.

**28. Action Required:**
Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
The PIC has worked with the Cope Foundation Human Resources Department to ensure that this action has been carried out. All relevant documentation is now on file for the individual staff member

**Proposed Timescale:** 25/01/2016