

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by COPE Foundation
<b>Centre ID:</b>	OSV-0003297
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	COPE Foundation
<b>Provider Nominee:</b>	Colette Fitzgerald
<b>Lead inspector:</b>	Kieran Murphy
<b>Support inspector(s):</b>	Mary Dunnion (day one)
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	56
<b>Number of vacancies on the date of inspection:</b>	4

## 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 following notification of a significant incident or event. 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:
14 June 2016 09:00	14 June 2016 17:00
15 June 2016 08:30	15 June 2016 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

**Background to the inspection**

This was the second inspection of a centre that was registered as a designated centre with HIQA. The centre was managed by COPE Foundation who provided a range of day, residential and respite services in Cork. COPE Foundation was a not-for-profit organisation and was run by a board of directors and delivered services as part of a service agreement with the Health Services Executive (HSE).

**Description of the service**

The centre provided a home to 60 residents and was based in a congregated setting in a community on the north side of Cork city. Many of the residents had high support needs with some residents also having complex healthcare needs and there was evidence that residents were being supported to achieve and enjoy the best possible health.

It was evident that the staff working in the centre and the residents living there had very good, harmonious and respectful relationship; staff knew the residents and their families well. The majority of residents went home for periods of time and staff facilitated this approach. The person in charge outlined that most of the residents had lived in residential care all their lives and due to the ageing profile of the residents a dementia care project had commenced in the centre as part of the "Innovating the Future" project. At the initial stage of the project all service users within the centre over the age of 35 years with a susceptibility to developing dementia had a "screening" carried out. Another aspect of the project was on-going education for staff and families. This initiative is to be commended.

Accommodation was provided for residents in seven houses in an enclosed "campus style" environment. Four of the houses could accommodate eight residents; two other houses accommodating nine residents; and ten residents lived in the final house. All houses were fully furnished and decorated in conjunction with the individual resident's personal choice and taste. Each resident was encouraged and supported to personalise their bedrooms with pictures, ornaments or any items they chose. The communal space in the houses included a large sitting room, spacious sunrooms, separate dining rooms and kitchens.

#### How we gathered our evidence

As part of the inspection, inspectors met with the residents and families. Residents said to inspectors that they liked living in the centre. One family member said to the inspectors that they were very happy with the care being provided, describing it as "second to none".

Inspectors met with staff during the inspection and observed their interactions with the residents. Staff had good knowledge of each resident's individual needs and were seen to support residents in a respectful and dignified manner.

Inspectors also observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures. Some good practice was observed by inspectors. For example, during the first day of the inspection one resident was observed to have sustained a fall. Inspectors observed staff responding in an appropriate manner and supported the resident as set out in their care plan.

#### Overall judgment of our findings

There was some evidence of good practice. For example, residents in the centre received a community epilepsy outreach service, coordinated through the neurology and epilepsy department in Cork University Hospital. The epilepsy outreach service was established in 2014 to provide high-quality specialist epilepsy care to people with intellectual disabilities living in residential care.

In relation to obtaining residents' consent to treatment the centre had recently received approval from the ethics committee within Cope Foundation to carry out a qualitative research piece looking at the barriers for staff and families of those who work with individuals with a severe or profound level of disability when accessing healthcare services and making healthcare decisions.

The community pharmacist had undertaken audits of medication management reviewing issues like security/storage of medication, use of as required medication (PRN) and the medication administration record sheets.

Inspectors found that the person in charge had the necessary skills, knowledge and experience to discharge her duties. However, the person in charge was responsible for this centre and another designated centre managed by COPE Foundation in Cork city. Due to the size and layout of this particular centre and the complexity of the healthcare needs of some residents, inspectors were not satisfied that these arrangements were sustainable in the context of ensuring the effective governance, operational management and administration of both designated centres.

Of the 11 outcomes inspected, three were at the level of major non-compliance:

Outcome 7: Health & Safety and Risk Management

During the two days of inspection fire doors were noted to be held open by “wedges” throughout the centre.

Outcome 10: General Welfare and Development

During the inspection some residents were observed spending long periods of time not engaged in any meaningful activities throughout their day.

Outcome 14: Governance

There had not been two visits to review the quality and safety of care as required by the regulations. In addition, there had not been a formal annual review of the quality and safety of care of the service which was also a requirement of the regulations.

The Action Plan at the end of the report identifies other areas where improvements are needed to meet 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 National Standards for Residential Services for Children and Adults with Disabilities. These areas included:

- consultation with residents
- there were inconsistencies in the format and content of the person centred plans.
- some external/internal redecorating was required
- some environmental restrictions required review
- staffing
- the system of records management did not adequately ensure that relevant healthcare information was available to plan care for residents.

**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):**

No actions were required from the previous inspection.

**Findings:**

Issues relating to residents' rights and dignity were reviewed on the inspection.

There was an arrangement in place whereby one resident from another centre attended the day service on campus in the morning. Staff said to inspectors that due to the increased noise levels in the day service in the afternoon this resident went to one of the houses in the designated centre for the afternoon, before returning to their own residential service in the evening. However, there was no evidence of any consultation with the existing residents in relation to these day arrangements for a resident from another designated centre.

In relation to privacy and dignity there were a number of shared double bedrooms and screens were available to safeguard the privacy of residents who were sharing these bedrooms. However, a number of bathrooms were accessible from adjacent bedrooms but there was no signage available to indicate to residents that the bathroom was in use which could compromise a resident's right to privacy while attending to personal care.

**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):**

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

**Findings:**

There were two sets of resident records; the person centred planning folder and a separate file for medical/healthcare records. There were inconsistencies in the format and content of the person centred plans.

The person in charge outlined that a "pilot" project was in place to review the format and content of the person centred plans for the eight residents living in one of the houses. The outcome of this "pilot" would inform the use of the new format throughout the centre. The person centred planning folders in the "pilot" reviewed by the inspectors were in an accessible format. There was a summary profile of the resident which outlined things that staff and carers must know about the resident, a communication profile which outlined what supports the resident needed to communicate. There was also a summary of healthcare issues and an appointment record for healthcare reviews.

There were separate assessments of residents' healthcare needs and social care needs in the personal planning process. In relation to healthcare needs, the person centred planning folder contained comprehensive health action plans related to the resident's assessed healthcare needs which provided up to date information in relation to each assessed healthcare need. The supplementary information in relation to these healthcare needs was in the separate file for medical records. Inspectors were satisfied that the care planning process used gave direction and coordination to care delivered to residents who had multiple complex healthcare care needs. For example, up to date records of referrals to consultant specialities were maintained for all residents. In particular there was evidence of follow up communication with hospitals in relation to planned procedures and out-patient appointments.

In relation to social care needs of residents, in the "pilot" person centred planning folders there was evidence that each resident was supported to develop an individual lifestyle plan each year called "things I would like to happen". In one example the resident's personal plan was reviewed in March 2016 and items identified for the resident included music, family outings, and "going for spins". However, the review of the personal plan did not meet the requirements of the regulations as it was not multidisciplinary. It was recorded that the assessment meeting for this resident's

personal plan had been attended by the person in charge and the clinical nurse manager. At this care planning review process it had been identified that an assessment of activities was required by an occupational therapist. This assessment was a necessary part of the personal planning process itself. In addition, the occupational therapy assessment had not been completed by the date of inspection in June 2016.

In relation to the other person centred planning folders not part of the "pilot" project improvement was required as all residents did not have an updated personal plan. For example, the personal plan for one resident included social care needs that had not been updated since 2014. The support plan for this resident included a daily timetable from 2013, an art therapy report from 2013 and an occupational therapy report from 2010.

**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):**

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

**Findings:**

Accommodation was provided for residents in seven houses in an enclosed "campus style" environment. Four of the houses could accommodate eight residents, with two other houses accommodating nine residents and ten residents lived in the final house.

In general the houses were all well maintained. All rooms were fully furnished and decorated in conjunction with the individual resident's personal choice and taste. The person in charge outlined that new furniture was being purchased for a number of the houses. Each resident was encouraged and supported to personalise their bedrooms with pictures, ornaments or any items they chose. The communal space in six of the houses included a large sitting room, spacious sunroom, separate dining room and kitchen.

However, inspectors saw that one resident's bedroom had a board on the wall running the width of the bed which staff indicated was to protect the resident's head. However this board had not been painted and was left with caulk marks clearly visible where the board had been screwed into the wall. Similarly in one bedroom an unpainted board had been put up to prevent the ceiling track hoist from damaging the wall.

**Judgment:**  
Substantially Compliant

**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):**

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

**Findings:**

Inspectors found that the arrangements for risk management were adequate. However, some improvement was required in relation to fire safety.

The person in charge told inspectors that she was in the process of developing a centre risk register and had completed a draft risk register for one house. This register was designed to log all the hazards that the organisation was actively managing. There were 40 hazards on this risk register which were mainly health and safety issues like moving/handling, slips/trips/falls and fire. The draft risk register also included specific hazards including accidental injury, aggression/violence, self-harm and unexpected absence.

For residents who required it, there were clinical risk assessments in place. For example, one resident with diabetes mellitus had a risk assessment in place, in addition to a care plan in their healthcare record.

Inspectors reviewed the incident reporting records from April 2016 to June 2016. There had been 53 incidents recorded including 16 resident falls, 19 reported incidents where a resident struck a staff member or a fellow resident. There was a system in place to ensure that all incidents were followed up by the person in charge and were reported to senior management of the service at a regional level to review for trends.

Records indicated that all staff had been trained in fire safety management. All staff spoken with knew what to do in the event of a fire, including the evacuation routes and assembly points. Each resident had a personal emergency evacuation plan in place which indicated what supports, if any, residents needed to leave the building in the event of a fire. However, during the two days of inspection fire doors were noted to be held open by "wedges" throughout the centre.

The centre was visibly clean throughout and staff spoken with were knowledgeable about cleaning and control of infection. A number of residents had been identified as having an infectious disease. While staff were aware of this and the precautions in place to support these residents, a care plan was not always in the resident's healthcare file.

**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):**

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

**Findings:**

Measures to protect residents being harmed were in place. A restraint-free environment was promoted. However, improvement was required in relation to some environmental restrictions.

It was a requirement of the regulations that all serious adverse incidents, including allegations of abuse were reported to HIQA. There were four significant allegations submitted to the Chief Inspector since the last inspection. Documentation in relation to these incidents was reviewed during the inspection. There was evidence that the issues raised had been investigated in accordance with centre policy on prevention of abuse of residents. Inspectors did note that the file for one of the incidents had been investigated but was still "open".

The service provider was obliged to notify HIQA on a quarterly basis of any occasion on which restraint was used (such as physical, environmental or chemical). HIQA was notified in March 2016 that 10 residents had bedrails in place as a restraint while they were in bed, 17 residents had lap belts in place for using wheelchairs as prescribed by an occupational therapist and one resident used padded gloves. The COPE Foundation policy and guidelines for the prevention of/use of restrictive interventions was made available to inspectors. The policy outlined that the organisation aspired to a restriction free environment.

There was a COPE Foundation restrictive interventions review committee provided oversight of all restrictions in the centre. There was evidence of good practice in relation to some restraint, particularly oversight by the restrictive interventions review committee. There were records available to demonstrate that the person who was subject to the restrictive procedures was being closely monitored to evaluate the risks to their physical, psychological and emotional wellbeing and to ensure the procedures are minimal in time and in extent.

However, environmental restrictions were in place in some areas of the centre such as a bedroom, wardrobes and kitchens. Improvement was required to ensure a rationale for restricted access was documented clearly and these restrictions required review by the restrictive interventions review committee to ensure they were proportional to the needs of residents. In addition, individual support plans did not have regular evaluation of same, which was required under the COPE Foundation policy.

**Judgment:**

Substantially 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):**

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

**Findings:**

During the two days of the inspection some residents were observed spending long periods of time not engaged in any meaningful activities throughout their day.

Some residents, including all eight residents from one house, attended a day service which was based on the campus. There were also some one-to one activities for residents with staff from day service as well as volunteers facilitating individualised activities. However, other residents were not always facilitated to participate in an activities programme that was based on individual need, capacity and preference. For example, the activity record for one resident over a six day period had a "walk around the grounds" on three days, music (one day), a "spin"(one day), visiting family (one day). Another resident's person centre plan had a "ring stacking recording sheet" which had not been filled in since 2014. This resident's activity profile dated from 2013 and included "bowling" records from 2013.

Over the two days of the inspection, staff said that they were short-staffed and inspectors observed that this impacted on residents being afforded the opportunity to engage in activities outside their home.

As was found on the previous inspection of this centre in December 2013 there was scope to extend the social, educational and community integration opportunities for residents, and particularly to provide a more individualised one-to-one social development programme with residents who had severe to profound disabilities. For example, the inspectors observed staff taking residents, in groups, for walks around the

grounds over the two days of the inspection. In addition, transport was only available on set days for the residents of each house so that access to community based activities was limited.

**Judgment:**  
Non Compliant - Major

### **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):**

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

#### **Findings:**

Residents were being supported to achieve and enjoy the best possible health.

The person in charge outlined that there was a general practitioner (GP) who reviewed residents, as required, in the centre. The inspectors reviewed a sample of resident healthcare files and found evidence of regular GP reviews.

There were up to date records of referrals to consultant specialists maintained for all residents and in particular there was evidence of follow up communications with hospitals in relation to procedures.

Residents in the centre received a community epilepsy outreach service, coordinated through the neurology and epilepsy department in Cork University Hospital. The epilepsy outreach service was established in 2014 to provide high-quality specialist epilepsy care to people with intellectual disabilities living in residential care. The epilepsy outreach service visited residents in their home environment and provided ongoing telephone-based care in between visits. The clinical nurse manager was the link person from the centre and she was of the opinion that this initiative improved seizure control, reduced the burden of seizure-related injuries, reduced the adverse side-effects from medication and improved the involvement of residents, carers and families in the management of epilepsy.

There was evidence that residents were referred, as required, to allied health professionals. Inspectors saw evidence in resident healthcare plans of reviews by the speech and language therapist with reports detailing safe swallow recommendations and advice on food consistency.

Inspectors spoke with the clinical nurse specialist who was available to support residents with communication needs. Inspectors reviewed residents' personal plans and found that where residents had communication needs, this was captured in personal plans. A number of residents had communication "passports" in picture format which clearly outlined their background, family support, home life, work life, likes/dislikes and any particular area where support was required.

It was a requirement of the regulations that all serious adverse incidents are reported to HIQA. Following an incident COPE Foundation at the request of HIQA, had undertaken an investigation into healthcare. This review had identified that improvement was required in the recording and monitoring of assessed healthcare needs. During the inspection there was evidence of accurate recording of care provided.

In relation to obtaining residents' consent to treatment the centre had recently received approval from the ethics committee within Cope Foundation to carry out a qualitative research piece looking at the barriers for staff and families of those who work with individuals with a severe or profound level of disability when accessing healthcare services and making healthcare decisions.

Dinner was prepared off site and the inspector observed the delivery of food in thermally insulated trolleys. Staff adapted the meals to accommodate individual residents' food preferences or dietary requirements. Due to some residents' dependency levels staff assisted these residents with their meals. Staff were observed assisting residents in a sensitive manner and engaged in a positive way with residents throughout the meal.

**Judgment:**  
Compliant

## **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:**  
Medication management policies and practices were satisfactory.

There was a comprehensive medication policy that detailed the procedures for safe ordering, prescribing, storage, administration and disposal of medicines.

Medications for residents were supplied by a community pharmacy. Staff confirmed that there was appropriate involvement by the pharmacist in accordance with guidance issued by the Pharmaceutical Society of Ireland. On the second day of inspection the pharmacist was on site to undertake an audit of medication management reviewing issues like security/storage of medication, use of as required medication (PRN) and the medication administration record sheets. The overall assessment of medication management standard was found to be "very good".

Staff with whom inspectors spoke confirmed that there was a checking process in place to confirm that the medicines delivered correspond with the medication prescription records. Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.

The person in charge outlined that she had completed a certificate in nurse prescribing in University College Cork in 2013 which gave her the authority to prescribe medicines. She was clear that she only prescribed medicines within her scope of practice. She outlined that this gave her the opportunity to enhance the care provided to residents through the use of her prescriptive authority.

Staff demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. Residents' medication was stored and secured in a locked cupboard in each premises and there was a robust key holding procedure. On the first day of inspection the person in charge confirmed that a medicines requiring refrigeration was stored in a house fridge. However, this was medication was moved to medication only fridge and stored securely.

A sample of medication prescription and administration records was reviewed by an inspector. Medication prescriptions were transcribed by the supplying pharmacy. Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications.

Resident specific medication administration procedures had been developed where appropriate. The procedures were person centred and gave clear guidance to staff in relation to administering medications to the resident in line with their wishes and needs.

One medication error had been recorded on the incident reporting system from April 2016 to June 2016. This incident had been followed up appropriately by the person in charge.

**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):**

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

**Findings:**

The centre was managed by a suitably qualified, skilled and experienced person in charge. However, improvement was required in relation to the management systems in place.

The person in charge had been appointed in 2015 and was a registered nurse in intellectual disability. She had a degree in nursing studies from UCC and a postgraduate diploma in multiple and complex disabilities also from UCC. The person in charge was responsible for this centre and another designated centre managed by COPE Foundation in Cork city. Due to the size and layout of this centre and the complexity of the healthcare needs of some residents, inspectors were not satisfied that the person in charge could ensure the effective governance, operational management and administration of both designated centres.

The person in charge reported to the director of homes and community who outlined to the inspectors that her role was to provide oversight of this centre and a number of other designated centres in Cork. The management of the centre also included two clinical nurse managers who were also registered nurses in intellectual disability. Both clinical nurse managers worked on opposite days

There were records to show that the director of homes and community had undertaken five separate reviews on site including issues like the risk register, health concerns, annual leave and furnishing for the centre.

Since the last inspection the service had put a performance management and development system in place for staff. Inspectors saw documentation relating to one such performance review and it included a summary of the staff member's work, training and put a plan in place in relation to training and development. The person in charge outlined that this year's performance reviews were due for completion.

The service provider had ensured that an unannounced visit had been completed in May 2015 that reviewed the quality and safety of care and support in the centre. Whilst it was apparent throughout the inspection that overall the quality and safety of residents care was well managed it is regrettable there had not been two further such visits to

review the quality and safety of care as required by the regulations. In addition, there had not been a formal annual review of the quality and safety of care of the service which was also a requirement of the regulations.

**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):**

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

**Findings:**

The number, qualifications and skill mix of staff required review to ensure that the assessed needs of residents were being met.

Inspectors met with staff during the inspection and observed their interactions with the residents. Staff had good knowledge of each resident's individual needs and were seen to support residents in a respectful and dignified manner.

The staff rota was made available to inspectors. As outlined in Outcome 10: General Welfare and Development it was noted there were reduced staffing levels throughout the centre on the two days of the inspection. The person in charge outlined that there were five staff members on long term leave but only three of these posts had been filled.

The person in charge acknowledged that the support needs for some residents particularly in one of the houses in the centre was increasing changing rapidly. Staff reported and evidence during inspection that residents with increasing physical dependencies required more intensive healthcare nursing support and interventions. Inspectors noted that there was a significant reduction of staffing in this house between day time and night time

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies the programme reflected the needs of residents.

Inspectors met with volunteers who were involved, in a supervised way, in supporting residents to pursue various activities and interests both within and outside of the centre. There were volunteer agreements in place which outlined roles and responsibilities of volunteers.

**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):**

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

**Findings:**

While there was a records management policy in place, the management of healthcare records required improvement.

In healthcare files seen by the inspectors relevant documentation were filed in a haphazard manner in the back "pocket" of the healthcare record. This included results of blood tests, appointment records and letters from healthcare professionals. This system of records management did not adequately ensure that relevant healthcare information was available to plan care for residents.

The copy of the COPE Foundation policy and guidelines for the prevention of/use of restrictive interventions provided to inspectors was noted to be due for review in April 2016.

**Judgment:**  
Substantially Compliant

## 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:***

Kieran Murphy  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by COPE Foundation
<b>Centre ID:</b>	OSV-0003297
<b>Date of Inspection:</b>	14 June 2016
<b>Date of response:</b>	10 August 2016

### 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:**

There was no evidence of any consultation with the existing residents in relation to day arrangements for a resident from another designated centre.

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

**1. Action Required:**

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

A residents forum was held within this residence to ensure that consultation occurred in relation to this action.

The PIC will liaise with staff to ensure that guidelines on this visit is adhered to all staff.

**Proposed Timescale:** 10/08/2016

**Theme:** Individualised Supports and Care

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

A number of bathrooms were accessible from adjacent bedrooms but there was no signage available to indicate to residents that the bathroom was in use which could compromise a resident's right to privacy while attending to personal care.

**2. 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:**

Signage is now visible on all bathroom doors within the designated centre to ensure that the residents privacy and dignity is respected at all times. This will be monitored through audits carried out by the PIC and PPIM's

**Proposed Timescale:** 10/08/2016

**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:**

Not all residents had an updated personal plan.

The review of the personal plan was not multidisciplinary.

**3. 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:**

The PIC will ensure that all residents within the designated centre have a multidisciplinary personal plan. These personal plans will be developed in an accessible format ensuring that residents and families are included in the development and review of same.

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

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

Some painting work needed to be completed.

**4. 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:**

The PIC has liaised with maintenance department and will ensure that this painting work is completed.

**Proposed Timescale:** 31/08/2016

**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:**

While staff were aware of this and the precautions in place to support residents with infectious diseases, a care plan was not always in the resident's healthcare file.

**5. 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:**

A health action plan and individualised risk assessment will be carried out and placed in personal plans of individual residents deemed at risk of healthcare associated infections and infectious diseases.

**Proposed Timescale:** 10/08/2016

**Theme:** Effective Services

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

Fire doors were noted to be held open by "wedges" throughout the centre.

**6. 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:**

All "wedges" have been removed from the designated centre. The PIC and PPIM's will ensure compliance through monitoring and audit.

**Proposed Timescale:** 05/07/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Improvement was required to ensure a rationale for restricted access was documented clearly and these restrictions required review by the restrictive interventions review committee to ensure they were proportional to the needs of residents.

**7. 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:**

Applications have been submitted to the Restrictive intervention committee in relation to the use of environmental restrictions within the designated centre.

Site specific guidelines in relation to the use of all restrictive interventions will be developed including the guidance on the use of environmental restrictions within the designated centre.

**Proposed Timescale:** 30/09/2016

## Outcome 10. General Welfare and Development

**Theme:** Health and Development

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

13(2)(b) Residents were observed spending long periods of time not engaged in any meaningful activities throughout their day.

**8. Action Required:**

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

The Person in charge will review current activation procedures and routines within all residences in the designated centre. Two staff will co-ordinate activation on a daily basis.

In house activation will be encouraged at all times by members of the team. A committee within the designated centre will be developed to investigate options in relation to activation ensuring that all residents enjoy meaningful activation throughout their day. This committee will be chaired by the PIC. The on-going use of volunteers will also be utilised to promote meaningful activation.

**Proposed Timescale:** 30/10/2016

## 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:**

Due to the size and layout of this centre and the complexity of the healthcare needs of some residents and the shared governance arrangements provided to a second off site centre, inspectors were not satisfied that the person in charge could ensure the effective governance, operational management and administration of both designated centres.

**9. Action Required:**

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

A business plan will be developed and submitted to the relevant funding body for the funding of a Person in Charge for this additional designated centre.

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

**Theme:** Leadership, Governance and Management

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

There had not been two visits to review the quality and safety of care as required by the regulations.

**10. 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:**

The provider nominee will carry out an unannounced visit to the designated centre

**Proposed Timescale:** 30/09/2016

**Theme:** Leadership, Governance and Management

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

There had not been a formal annual review of the quality and safety of care of the service which was also a requirement of the regulations.

**11. 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:**

The provider nominee will nominate a suitable designated person to carry out an annual review.

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

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The number, qualifications and skill mix of staff required review to ensure that the assessed needs of residents were being met.

**12. 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 staffing levels within the designated is currently being undertaken within the organisation.

The organisation is currently in communications with the relevant funding bodies. A Business case has been submitted to the relevant funding body in relation to increased staffing on night shift. Awaiting outcome of same.

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

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

The copy of the COPE Foundation policy and guidelines for the prevention of/use of restrictive interventions provided to inspectors was noted to be due for review in April 2016.

**13. Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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 policy review forum is organised for September 2016. The prevention of/use of restrictive interventions policy is due for review at this forum.

**Proposed Timescale:** 30/09/2016

**Theme:** Use of Information

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

Relevant healthcare records were not easily accessible.

**14. 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:**

The PIC will ensure that all relevant healthcare records are filed and maintained in an appropriate manner to ensure ease of accessibility to all members of the team within the designated centre.

**Proposed Timescale:** 30/09/2016