Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003305
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Colette Fitzgerald
Lead inspector:	Kieran Murphy
Support inspector(s):	Julie Hennessy
Type of inspection	Announced
Number of residents on the date of inspection:	20
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.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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

From:	To:
16 February 2016 10:00	16 February 2016 17:00
17 February 2016 09:00	17 February 2016 16:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the first inspection of a centre that had made an application to register as a designated centre with the Authority. 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).

The centre was based in a large town in East Cork. The centre was a congregated setting provided a home to 20 residents on a five day basis from Monday to Friday.

The centre provided both residential and respite accommodation. Respite care is alternative care for a person with a disability for a short period from their usual accommodation at home. The person in charge maintained a record of all residents who accessed the service on a respite basis. Part of the centre included a day service that supported other people with an intellectual disability from the locality.

As part of the inspection, inspectors met with the residents, families and staff members. Residents said to inspectors that they liked living in the centre. Feedback sheets were also received from fourteen families during the inspection. In general the feedback about the centre was positive with one family commenting that their loved one "gets excellent care from wonderful caring staff".

Inspectors were satisfied that the person in charge was suitably qualified and experienced to discharge her role. There were suitable support arrangements in place to enable the person in charge to effectively undertake the role. In particular the person in charge was supported by the team leader who was nurse in intellectual disability with appropriate skills, knowledge and experience. In relation to the overall governance structures for COPE Foundation in East Cork the provider nominee had submitted to the Authority a new operational management structure. The team leader position was to be the person in charge of this centre and another centre in a nearby town in East Cork. Both centres would also have an additional staff member appointed to support the person in charge.

In relation to residents in this centre six people received full-time residential care in Cope Foundation services; from Monday to Friday in the centre and at the weekends these residents were accommodated in regular, alternative accommodation in Cope Foundation. Families expressed their concerns to inspectors regarding the fact that the centre was only open for five days per week. One family member said that "I would prefer if people did not have to leave every weekend and go to a different centre for respite care". COPE Foundation had made a submission in February 2016 to the Health Service Executive (HSE) to allocate further staff to make the centre a seven day service. In their submission COPE Foundation outlined that this would "eliminate the need to find alternative accommodation elsewhere for six residents".

Of the 18 outcomes inspected three were at the level of major non-compliance:

Outcome 1: Rights of residents and dignity
The designated centre was part of a building that also included a day service that supported all residents living in the centre. In addition, other people with an intellectual disability from the locality also attended the day service. During the two days of the inspection all people attending the day service accessed the residential part of the building to have their lunch. Inspectors found that this practice did not respect the privacy and dignity of people living in the centre. In addition, there were eight double bedrooms. However, there was no evidence of consultation with residents regarding the sharing of their bedrooms.

Outcome 5: Social Care needs
Overall, while residents had a personal plan, there was no link between the assessment process, the setting of personal goals and the review of the personal

plan.

Outcome 8: Safeguarding and safety
There were digilocks on doors leading to resident bedrooms which was a restriction on people's ability to access their own personal living space.

Other areas for improvement included:
- Contracts of care
- premises
- healthcare planning
- staff training
- lack of access to community based programmes
- risk management including infection control and fire drills
- records management
- statement of purpose
- medication management.

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 designated centre was part of a building that also included a day service. All residents living in the centre attended the day service. In addition, other people with an intellectual disability from the locality also attended the day service. One of the families in feedback to inspectors said that "residential care should be separate to the day centre". During the two days of the inspection all people attending the day service accessed the residential part of the building to have their lunch. This meal was provided in a canteen style dining area due to the large numbers of people eating lunch each day. There were two separate sittings with some people having the "early" lunch and others having the "late" lunch. COPE Foundation in a recent review of quality and safety of care in the centre had identified the practice of everyone from the day service accessing the designated centre for lunch as an intrusion on residents' personal and private space. This was also observed by inspectors.

Inspectors saw evidence that residents were consulted with and participated in the organisation of the centre. The most recent formal residents meeting was in October 2015 where the role of the key worker was discussed with residents. However, the staff team leader had recently been trained as an advocacy champion. She encouraged staff to have informal meetings each night with residents to see if there were things that they unhappy about. One family did say to inspectors that their family member "makes decisions on his daily life like what to eat and where he wants to go". Another family said that another resident "was asked to go on outings in the evenings but his decision not to go is respected."

The centre provided both residential and respite accommodation. There were eight double bedrooms. The family of one resident who shared a bedroom said to inspectors that their loved one was happy to share their bedroom and was best friends with their roommate. Some residents had to share bedrooms with people who accessed the service on a respite basis. However, there was no evidence of consultation with residents regarding the sharing of their bedrooms. Privacy screening was not available in shared bedrooms and there wasn't evidence of consultation with residents as to whether they wanted privacy screening in shared bedrooms.

The organisation had a complaints policy and easy-to-read versions were visibly displayed throughout the centre. Feedback received from families and residents indicated that they knew how to make a complaint. Inspectors reviewed the complaints log and there had been five complaints recorded since January 2015:
- Two complaints related to clothes going missing
- one related to a maintenance issue
- one related to accessibility of the premises (this is discussed in more detail under Outcome 6: premises)
- one related to medication management.

The complaints policy identified a nominated person to manage complaints in the organisation. However, it did not identify a second person to oversee how complaints were managed, as required by the Regulations and as a result, the appeals process was not clear.

There was a policy on closed circuit television (CCTV) and the person in charge confirmed that CCTV was in use on external parts of the building only.

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:
Residents with communication needs had access to medical consultants and allied health care as required, including audiology and speech and language therapy. One of the resident's families in feedback to inspectors said that their loved one had finished "a communication course before Christmas and is talking more at home since".

Inspectors reviewed residents' personal plans and found that where residents had communication needs, this was captured in personal plans. For example, information in personal plans included whether residents communicated verbally or by using non-verbal communication means, how residents communicate when they are in pain or when being assisted with personal care, during mealtimes or when out in the community. Behaviour support plans also included key information in relation to what residents may be communicating through certain behaviours.

Staff were observed over the course of the inspection to support residents to communicate. Some residents with identifiable communication needs had a communication passport in order to ensure that staff would support residents in a consistent manner. Some of the passports were in a format that helped residents to turn the pages themselves. They provided guidance as to how the person communicated including:

- Verbal communication
- Gestures
- Things I like to communicate about
- Things I like
- Things that upset me
- Things that cheer me up
- Things I am good at.

Judgment:
Compliant

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 saw that residents were supported to develop and maintain personal relationships and links with the wider community and families were encouraged to get involved in the lives of residents.

Inspectors met a number of families during the inspection who confirmed there was good communication between residents, families and the service. One family said that this was particularly the case as residents went home each Friday.

Residents were involved in activities in the local and wider community including meals out, bowling, local sporting events and concerts in the local area.

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:
Not all residents had a written contract of care, as residents availing of the respite service did not have a contract. Where a written contract was in place, it had been signed by the resident or their representative which dealt with the support, care and welfare of the resident in the centre and included details of the services to be provided. However, the contract did not specify the type of service provided to residents in this centre i.e. that it was a five-day service.

There had not been any new admissions to the centre since commencement of the Regulations. The policy on admissions, transition and discharge of residents, which had been reviewed in October 2015, was made available to inspectors. The policy took account of the need to protect residents from abuse by their peers.

The general criteria for admission to the organisation's service was clear and transparent. However, the admission criteria outlined in the policy and the statement of purpose relating to this service was too broad. The policy stated that the eligibility for admission was determined by age, family circumstances and those already accessing the organisation's services.

Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Each resident had a personal plan. Significant work had been completed with personal plans to make them accessible for residents. Personal plans contained a personal profile, pictures of residents' family and friends, personal goals, individual likes and dislikes, week-day activity schedule, health assessments and checks, a self-assessment questionnaire, a support plan for intimate care, activities and outings, information regarding residents' preferred communication methods, behaviour support plans (if required) and a record of visits and contacts with family and friends. Residents knew their plans and some residents told inspectors about their plans.

One family in feedback to inspectors said they felt that "all social and development needs are met". However, it was not demonstrated that families were invited to participate in the development of personal plans with residents, where appropriate.

An assessment was in place with respect to residents' healthcare needs. However, a comprehensive assessment was not in place for all residents, particularly for residents who availed of respite services. In addition, the assessment of residents' healthcare needs did not always inform other required plans, such as healthcare plans or risk assessments, as required to ensure the consistent delivery of care and support to residents. For example, where residents had mobility or communication needs, a communication care plan, a mobility care plan or a falls risk assessment had not been completed in some cases. Each resident was to have an annual "OK health check" which was a global health assessment undertaken by nursing staff. However, COPE Foundation had identified in their own annual audit of quality of care of residents, described in more detail in Outcome 14: Governance, that this assessment had not taken place for all residents.

A comprehensive assessment had not been completed with respect to residents' social and personal development needs, as required by the regulations. As a result, personal plans were not based on an assessment of residents' health, personal and social abilities, aspirations or identified areas of need. In turn, this meant that the person in charge could not always demonstrate that residents' needs and full potential in terms of independence were being fully supported.

Inspectors found failings with respect to the review of residents' personal plans. There was no formal process in place to review the personal plan annually or more frequently if there is a change in needs or circumstances or to ensure that such a review was multidisciplinary, as required by the Regulations. As a result, families did not have the opportunity to attend an annual review.

In addition, the review of the personal plan was not multi-disciplinary, as required by the Regulations. The impact of failings regarding the multidisciplinary review of the personal plan was evident in a number of ways. The suitability of the centre to meet the needs or abilities of residents' was not being assessed and reviewed with the multi-disciplinary team. Also, long-term goals, such as where a resident may wish to live in the future and with whom or personal development goals were not included in the personal plan. As part of the audit of quality of care for residents described in more detail in Outcome 14: Governance COPE Foundation had identified that personal plans for residents were not up to date and that "goal setting in the care was short-term with emphasis needed to have a longer outlook to meet individual's life goals".

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The centre was a congregated setting that provided a home to 20 residents on a five day basis from Monday to Friday. Part of the building included a day service that supported other people with an intellectual disability from the locality.

The residential centre had four individual bedrooms and eight double bedrooms. Three of the bedrooms had inter-connecting bathrooms. All bedrooms were fully furnished and decorated in conjunction with the individual resident's personal choice and taste. However, not all bedrooms had suitable storage facilities for clothes and personal items and some residents in the double rooms had to share wardrobes.

The two main bathrooms had a bath, shower, toilet and wash hand basin. In relation to the bathrooms one of the families outlined that when the centre was being built that they "had requested a bidet be installed in ladies bathroom and also that all rooms would have en suites but this had not been done either at the time or subsequently". The baths in the two main bathrooms were not accessible by residents and the person in charge said that they were used rarely, if at all. In addition, one resident who had restricted mobility and used a wheelchair showed inspectors how the design and layout of the bathrooms made it difficult to manoeuvre the wheelchair in the bathroom. This

was also observed for this resident in their bedroom.

One of the complaints that had been logged with COPE Foundation service related to the accessibility of the corridors. The resident had said that they needed wider space on the corridors for their wheelchair. This was in the context of a fire evacuation from the resident's bedroom and an alternative exit arrangement had been identified by the service for the resident.

There were a number of living areas including a large kitchen and two sitting rooms where residents relaxed and watched television. However, inspectors observed that the premises did not provide suitable communal facilities for residents. One of the sitting rooms had enough seats for six residents to sit comfortably. The other 14 residents only had the other sitting room to relax in the evening. One of the families in feedback to inspectors said that the centre needed "more room for residents".

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:
There was a risk register in place with 27 separate hazards on this register including fire, self-harm, injury and challenging behaviour. There were two methods of recording incidents and accidents. Inspectors saw records from January 2015 to February 2016. There had been:
• Three medication management incidents
• two resident falls
• three incidents of residents hitting staff or other residents
• one incident of a residents wandering at night
• one incident where a resident had an unexplained cut on their eyebrow.

There had been 16 recorded accidents including nine resident falls, three episodes of residents having an epileptic seizure and three lacerations/bruises. There was evidence that all accidents and incidents had been followed up appropriately.

Risk assessments had been completed where individual residents were at risk of injury or harm. However, it was not demonstrated that the system in place was robust. In most cases the residual risk, i.e. the risk rating after controls had been implemented, was not recorded. A risk assessment had not been completed for all risks and it was not

demonstrated that the effectiveness of control measures were being regularly monitored and reviewed. For example, for a resident with mobility needs, a manual handling assessment of specific tasks that involved moving and handling was not available. In another example, there was no risk assessment for the risk of a specific healthcare associated infection.

Where residents were at risk of falls, it was demonstrated that residents had access to members of the multidisciplinary team, including a doctor, physiotherapy and occupational therapy. However, the management of falls was not adequate. For one resident at risk of falls, the additional control measure identified in the risk assessment identified was that a falls assessment was to be carried out. However, this had not been completed. In addition, the risk was rated as 'low', which contradicted other information in the resident's file. For another resident who had a high risk of falls, the risk assessment did not specify the steps to be taken following a fall. The relevant policy contained a 'fall algorithm' which outlined clear steps to be taken in different falls scenarios but it was not demonstrated that this process was being followed. Instead, falls were treated as single events and while medical attention was sought, the follow up action to prevent re-occurrence was not clear.

With respect to the prevention and control of infection, the centre followed the Health Service Executive (HSE) information booklet for Community Disability Services (2012). The centre was visibly clean with arrangements in place in relation to cleaning and laundry management, such as colour-coded systems. Facilities were available for hand hygiene. Personal protective equipment was available. The team leader had recently completed training as a hand hygiene assessor and an inspector viewed staff competency assessments relating to hand hygiene. Audits of the cleanliness of the environment had been completed. Staff told inspectors that they had access to advice from a community infection control nurse and residents' general practitioners in the event of any outbreaks of infectious disease.

However, improvements were required in order for the provider to demonstrate that the procedures in place for the prevention and control of healthcare-associated infections were adequate. There was no infection control policy or procedure in the centre that outlined what arrangements were in place to prevent and manage healthcare associated infections in the centre. For example, it was not clear what training was to be provided to staff, what steps to take in the event of an outbreak of an infectious disease and when risk assessments were to be completed and by whom. Where there was a risk of healthcare associated infection, there was no risk assessment in place to ensure that all staff were aware of the control measures in place and to allow for regular monitoring and review of the effectiveness of such controls. While staff were able to clearly articulate to inspectors what measures they would take to prevent specific infections, the arrangements were not sufficiently robust to take account of staff turnover, new staff or temporary staff or students working in the centre. According to training records, of the six permanent staff in the centre, only one had received training in hand hygiene and two in relation to infection prevention and control.

Inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:
• Servicing of fire alarm system and alarm panel January 2016

• servicing of emergency lighting January 2016
• fire extinguisher servicing and inspection May 2015.

All staff had received fire training. Fire evacuation maps were available and on display in each house. 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. A fire audit undertaken by COPE Foundation in October 2015 outlined that "there was a risk around some residents as they require a lot of support and encouragement to leave (the building) particularly at night." Since October 2015 there had been nine fire drills. However, the records reviewed did not demonstrate that the fire drills were effective as in only two instances was it recorded how long it took to evacuate the building and how many residents were present at the time. The times recorded for evacuation of residents for the two drills were both over five minutes.

Systems were in place to ensure that all vehicles used to transport residents were roadworthy, regularly serviced, taxed and insured. Inspectors reviewed a sample of daily checks that were completed for vehicles. Tax and insurance certificates were up to date for all vehicles assigned to the centre. Servicing records evidenced regular servicing of vehicles.

Judgment:
Non Compliant - Moderate

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:
The layout of the centre was that the bedrooms of female residents were on one corridor of the building and the bedrooms of male residents were on a separate corridor. There were digilocks on the doors leading to both these corridors. Inspectors observed two residents unsuccessfully trying to access their bedrooms during the day. These digilocks were in place and residents could not open the door to the corridors where their bedrooms were. A risk assessment was in place for such restrictions on residents accessing their bedrooms. However, it was not being followed. In addition, this restriction on residents' ability to access their own personal living space had not been

referred to or approved by the COPE Foundation restrictive interventions review committee.

Residents told inspectors that they felt safe in the centre and that they knew who to report any concerns to in the event of an incident occurring. Staff interactions with residents were observed to be appropriate and supportive. The organisation had a local procedure in place for the prevention, detection and response to abuse. Staff were aware of the procedure and the steps to follow in the event of an allegation, suspicion or incident of abuse.

Inspectors assessed the systems in place in the organisation to manage incidents or allegations of abuse. Overall, the systems in place to manage incidents or allegations of abuse were managed in a comprehensive way with due consideration of all involved. Multidisciplinary input was available. However, one area required improvement. Where an alternative process was in place, it was not clear from a resident's safeguarding plan who was responsible for ensuring that any recommendations or actions arising would be implemented.

There was a policy in place for the provision of personal intimate care. In each resident's personal plan was an individual support plan for personal intimate care.

Residents had access to behavioural therapy, psychology and psychiatry as required. Where residents required a behaviour support plan, one had been completed by a clinical nurse specialist in behaviour support therapy. A positive approach to the management of behaviour that may challenge was demonstrated. A skills assessment had been completed by the behaviour therapy department and positive reinforces had been assessed and were outlined. Staff demonstrated that they were familiar with how to implement the support plan in practice.

Inspectors reviewed a sample of records in the centre pertaining to the day-to-day management of residents' monies. Receipts viewed were signed by two staff. Records were kept of pocket money and any expenditure. An audit had been completed in January 2016 of residents' monies.

All staff had received training in understanding and reporting abuse. However, according to training records, two of six staff had not received training in relation to the management of behaviours that may challenge, as required by the Regulations. One staff was on extended leave and the person in charge had scheduled training for the remaining staff member.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
It is a requirement that all serious adverse incidents are reported to the Authority. A record of all incidents occurring had been maintained and all notifications had been sent to the Authority 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:
Each resident accessed a day service within the same building as the residential service. Residents living in the community also accessed the same day service. Residents told inspectors that they enjoyed their day service. Activities on offer varied depending on residents' choice and included arts and a wide variety of crafts such as knitting and sewing. One resident had a painting included in the COPE Foundation calendar for 2015.

Residents also participated in keep fit programs and went for frequent walks in the grounds of the day service. Residents also accessed community facilities via the day service, such as bowling.

The centre demonstrated a commitment to residents engaging in further education, training and lifelong learning. A number of residents had completed further eduation courses and had recently received certificates in advocacy from Cork Institute of Technology. One family said to inspectors that since living in the centre one resident had "learned to cook and is capable of looking after herself".

There was a policy available in the centre pertaining to access to education, training and development. However, a comprehensive assessment of residents' educational, employment and training goals was not available for all residents in order to ensure that

the day service programme was suited to individual residents' abilities or to explore options for community-based training and employment where applicable.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
The person in charge outlined that residents had the option of attending a general practitioner (GP) of their own choice and each resident usually attended their own family GP practice. In addition, the COPE Foundation service doctor was also available to residents. There was evidence of access to specialist care in psychiatry as required

For many identified healthcare needs, a care plan had been developed to direct the care and support to be provided to residents. For example, where residents were on a special diet, a care plan was in place relating to their altered consistency diet. Overall, required healthcare checks were completed, such as monitoring of blood pressure, blood glucose levels and any seizure activity. However, some gaps were noted. For example, where a resident was at risk of losing weight, weights were recorded using different metrics, meaning that it was not possible to determine whether that same resident was losing weight or not. The care plan did not provide direction as to when and how weights should be taken and recorded.

There was a policy on nutrition and hydration. There was evidence that residents were referred for treatment by to allied health professionals including speech and language therapy and dietetics. A number of residents had up to date swallow care plans and dietary reviews. All meals were prepared in the kitchen on site. The main meal was served at lunchtime with choices offered to residents. A copy of the menu was available on the notice board. Staff in the kitchen were knowledgeable about residents likes and dislikes and also knew which residents were on special diets.

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

Findings:
A sample of medication prescription and administration records was reviewed by an inspector. Nine residents brought their own medication in from home and their own family doctor completed the prescription record. For the other residents the prescription was transcribed by the pharmacist who also supplied the medication for these residents. In relation to residents who brought their own medication in from home staff confirmed that there was a checking process in place to confirm that the medicines delivered correspond with the medication prescription records.

Staff confirmed that there was appropriate involvement by the pharmacist who had recently undertaken an audit of medication management. A number of recommendations had been implemented from this audit including the development of a new method for recording administration of medication. However, inspectors noted a number of errors by staff in recording the administration of medication. For example, there was an omission of medication when one resident was on respite care. In another example night staff had signed for administration of medication in error over three nights.

Residents' medication was stored and secured in a locked cupboard in each premises and there was a robust key holding procedure. Staff confirmed that medicines requiring additional controls were not in use at the time of inspection.

In feedback received from families one family said that "nursing staff needed to be provided at night time". The team leader, who was a qualified nurse, said that either she or the nurse from the day service administered the morning medication to all residents. At night time medication was administered by non-nursing staff. Inspectors saw protocols in place for three residents in relation to the management of epilepsy in the event of an emergency. These protocols had been signed by the resident's doctor in all cases. However, training had not been provided to all non-nursing staff on the administration of emergency medication.

Three medication errors had been recorded on the incident reporting system from January 2015 to December 2015. There were two incidents where a resident had refused medication and another incident where medication prescribed for the morning had been given instead of night time medication. All reported incidents were followed up to prevent similar events in the future.

Judgment:
Substantially 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:
The statement of purpose was a document intended to describe the service and facilities provided to residents, the management and staffing and the arrangements for residents' wellbeing and safety. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. The stated aim of the centre was to "support each person to reach their full potential in development within a safe and homely environment.

The statement of purpose did not have sufficient information in relation to:
• That the centre was only open on a five day basis from Monday to Friday
• the specific care and support needs the centre was intended to meet, for example the statement of purpose said the centre provided care to people with "intellectual disability and autism"
• how many respite beds were available in the centre.

Judgment:
Substantially 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 provider nominee on behalf of COPE Foundation was a qualified nurse in intellectual disability nursing. She had an extensive remit of more than 15 designated centres geographically spread from Cork to Mitchelstown, Fermoy, Mallow and Kanturk.

The person in charge was responsible for this centre and another COPE Foundation centre in Cork city. The person in charge had 25 years experience working with persons with an intellectual disability and was a registered nurse in intellectual disability. The management of the centre also included a team leader who was a registered nurse in intellectual disability. The team leader worked in the centre from 9 am to 5 pm from Monday to Friday. The person in charge outlined that she attended this centre on a weekly basis and was in constant communication with the team leader.

In relation to the overall governance structures for COPE Foundation in East Cork the provider nominee had submitted to the Authority a new operational management structure. The team leader position was to be the person in charge of this centre and another centre in a nearby town in East Cork. Both centres would also have an additional staff member appointed to support the person in charge.

An annual review of the quality and safety of care of the service dated February 2016 had been completed. The review looked at five of eight care and support 'themes' namely:
• Supports and care for residents
• effective services
• safe services
• health
• workforce.

There was evidence of quality improvement following the annual review. For example, it had identified the need for an advocacy champion to help residents communicate issues of importance to them. Since the annual review the team leader had received training on this and was the lead for advocacy.

The provider had ensured that unannounced visits to each house within the designated centre had been completed; the first in September 2015 and the second in February 2016. Inspectors reviewed the report arising from such visits and found that visits required development in order to meet the requirements of the Regulations. However, while some key aspects of quality and safety of care being delivered were reviewed, other aspects were not.

There were a number of audits that had been completed including
• Medication audit August 2015
• automated external defibrillator (AED) bag audit January 2016
• hand hygiene audit February 2016
• report writing audit February 2016
• protected mealtime audit September 2015

There was evidence of learning from audits with actions identified and completed. For example the AED bag audit had identified that spare pads were out of date and that there were no spare AED pads available. This had been resolved by the team leader.

Judgment:
Substantially Compliant

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:
Inspectors found that adequate arrangements were in place through the appointment of a named person to deputise in the absence of the person in charge.

The person in charge had not been absent for a prolonged period since commencement and there was no requirement to notify the Authority of any such absence. The provider was aware of the need to notify the Authority in the event of the person in charge being absent.

Judgment:
Compliant

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:
Inspectors found that the centre was resourced to ensure the effective delivery of care and support in accordance with its current statement of purpose.

However, six residents received full-time residential care in Cope Foundation services; from Monday to Friday in the centre and at the weekends these residents were accommodated in regular, alternative accommodation in Cope Foundation. Families expressed their concerns to inspectors regarding the fact that the centre was only open for five days per week. One family member said that "I would prefer if people did not have to leave every weekend and go to a different centre for respite care". COPE Foundation had made a submission in February 2016 to the Health Service Executive (HSE) to allocate further staff to make the centre a seven day service. COPE Foundation said would "eliminate the need to find alternative accommodation elsewhere for six residents".

Judgment:
Compliant

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:
The feedback received from families of residents in relation to the care and support provided to residents by staff was in general very positive with one family saying that "staff go above and beyond the call of duty to assist and support residents". However, there was some conflicting feedback received from families regarding staffing levels. One family said that they "never had any reason to think there wasn't enough staff at the centre". However a number of other families said that the numbers of staff needed to increase, particularly at night. As part of the audit described in more detail in Outcome 14: Governance COPE Foundation had identified that staffing would be reviewed, particularly at night time, in the context of the changing needs of residents. This audit also acknowledged that the current staffing levels do not support residents to remain in the centre at weekends.

Inspectors saw that there was a planned and actual staff roster in place which showed the staff on duty during the day and sleepover staff at night. The centre was open Monday to Friday only. Currently three full-time and two part- time staff members were employed. The team leader worked daily from 8 am to 5 pm and two care assistants worked in the evening from 3 pm and slept in the centre at night.

There were two part time care assistants who worked alternate evenings between 5 pm and 10pm to facilitate activities, such as going to the cinema or the pub with friends. Staff endeavoured to meet residents wishes within current resources. Staff described how they meet with residents to determine their chosen activities that were then planned on a 'rotational' basis. One resident told inspectors that he would "like to go out more in the evenings if given the chance".

A policy relating to the recruitment, selection and vetting of staff was made available to inspectors which outlined robust procedures. 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. However, gaps were noted in relation to mandatory and training required to meet the needs of residents. One staff required training in relation to the management of behaviour that challenges and moving and handling and this had been scheduled by the person in charge. Training in infection control and hand hygiene had not been completed for all staff. In addition, an insufficient number of staff had received training in relation to the administration of emergency medication.

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:
Inspectors saw that the communication diary contained a number of original hospital consultant out-patient appointment records stapled into the diary. This filing method

could not guarantee the confidentiality of residents' personal information. In addition, it was not always clear if a plan of care for these identified healthcare needs was being developed prior to and following these healthcare appointments.

The filing system for healthcare records needed improvement. In one resident's healthcare file there were appointment records, reports of blood tests and consent forms all filed loosely in the back flap of the file.

A copy of the residents' guide was available in the reception areas. However, the residents' guide did not include the following items which were specified in the regulations:
• The terms and conditions relating to residency
• arrangements for resident involvement in the running of the centre
• how to access inspection reports
• the procedure for complaints.

A directory of residents was maintained in the centre and was made available to the inspector.

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[1]

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003305
Date of Inspection:	16 February 2016
Date of response:	31 March 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 consultation with residents regarding the sharing of their bedrooms. In addition, there wasn't evidence of consultation regarding the provision of privacy screening in shared bedrooms.

[1] 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:
The Person in Charge and Team Leader will ensure the consultation with residents regarding the sharing of bedrooms will be documented in residents' personal plans and include any requests for privacy screens; which will be provided if requested.

Proposed Timescale: 30/04/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
People from day service accessing the centre for lunch in a canteen style environment did not respect the privacy and dignity of people living in the centre.

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:
A meeting between the Person in Charge, Registered Provider and the Manager of the Day Service will be held. The continued use of the residential dining room by day attendees will be discontinued.

A plan to move the dining facilities for day attendees to an alternative location within the day centre will be put in place. Day attendees and their families will be informed and consulted regarding these changes.

Proposed Timescale: 29/07/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy identified a nominated person to manage complaints in the organisation. However, it did not identify a second person to oversee how complaints were managed, as required by the Regulations and as a result, the appeals process was not clear.

3. Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all

complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
The person in Charge will request Cope Foundation to review its current complaints policy with regards to a second person to oversee how complaints are managed as per regulation 34(3).

Proposed Timescale: 30/04/2016

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:
The admission criteria outlined in the policy and the statement of purpose relating to this service was too broad.

4. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
A site specific procedure for Admission to this centre will be created and inserted in the Statement of Purpose.

Proposed Timescale: 30/05/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents had a written contract of care as required by the Regulations, as residents availing of the respite service did not have a contract.

5. 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 organisation will develop a specific Contract of Care for Provision of Respite Services, separate from the Cope Foundation General Contract of Care.

Proposed Timescale: 30/05/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where a written contract was in place, it did not specify the type of service provided to residents in this centre i.e. that it is a five-day service.

6. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
Person in charge has commenced amending Contracts of Care and clarifying in the Contract that the service is 5 day in the residential centre.

Proposed Timescale: 30/04/2016

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:
A comprehensive assessment was not in place for all residents, particularly for residents who availed of respite services.

A comprehensive assessment had not been completed with respect to residents' social, employment, training and personal development needs.

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

Please state the actions you have taken or are planning to take:
Person in Charge and Team Leader are currently reviewing residents ' personal plans, and will ensure all residents, including residents availing of respite, will have a comprehensive assessment as per regulation 05(1)(b).

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assessment of residents' needs did not always inform other required plans, such as healthcare plans or risk assessments.

8. 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:
Person in Charge and team leader will review all residents' current care plans to ensure a comprehensive assessment of residents' needs are identified to include health care and risks assessments where appropriate as per regulation 5 (2).

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no formal process in place to review the personal plan annually or more frequently if there is a change in needs or circumstances.

9. 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 Person in Charge and Team Leader will schedule meetings with residents, their families, key workers and members of the multidisciplinary team to review their personal care plans. The annual review date will be agree at the end of each meeting.

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no process in place to ensure that the review the personal plan was multidisciplinary.

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

Please state the actions you have taken or are planning to take:
The Person in Charge and Team Leader will ensure that the annual review of residents' personal care plans will involve appropriate members of the multidisciplinary team as per regulation 05(6)(a).

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that families were invited to participate in the development of personal plans with residents, where appropriate and in accordance with residents' wishes, age and the nature of his or her disability.

11. 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:
Person in charge and team leader will organise a schedule of meeting inviting residents' families and/or representatives to participate in the development of personal plans after consulting with residents. All consultation with family members will be clearly documented in residents' personal care plans.

Proposed Timescale: 30/06/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The baths in the two main bathrooms were not accessible by residents and the person in charge said that they were used rarely, if at all. In addition, one resident who had restricted mobility and used a wheelchair showed inspectors how the design and layout of the bathrooms made it difficult to manoeuvre the wheelchair in the bathroom. This was also observed for this resident in their bedroom.

12. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
A review of all bathrooms will be carried out. Alterations to the 2 main bathrooms to provide suitable and sufficient sanitary conveniences which are readily accessible for residents will be provided. The toilet and bathroom facilities need to be re-designed to accommodate easy adaptation to suit the future needs of residents. Funding for these works will be applied for.

Proposed Timescale: 01/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all bedrooms had suitable storage facilities for clothes and personal items and some residents in the double rooms had to share wardrobes.

13. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
Additional bedroom storage will be purchased in consultation with residents. The PIC will ensure that separate storage is provided in double bedrooms for residents.

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises did not provide suitable communal facilities for residents.

14. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
A plan is being put in place to discontinue use of the current dining room by day attendees, this will create extra space. A third living area will then be created with a view to the garden and external access.

Proposed Timescale: 01/12/2016

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:
As detailed within the findings, it was not demonstrated that the systems in place in the designated centre for the assessment, management and on-going review of risk were adequate. In addition, the management of falls required review.

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

Please state the actions you have taken or are planning to take:
Staff training in Risk Management is currently being provided in the centre for all staff. The Person in Charge and Team Leader will review the current risks and control measures in place. Procedures for responding to emergencies will be part of this review.

The Risk Register in the residential centre will be updated to include the management of falls. Regular reviews will be undertaken by staff members with support from the person in charge and team leader.

Proposed Timescale: 30/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that residents who may be at risk of a healthcare associated infection were protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority:

There was no infection control policy in the organisation nor was there an infection control procedure available in the centre in relation to arrangements in place for the prevention and control of healthcare associated infections in this centre;

Where there was a risk of healthcare associated infection, there was no risk assessment in place to ensure that all staff were aware of the control measures in place and that the effectiveness of such control measures were regularly monitored and reviewed;

According to training records, of the six permanent staff in the centre, only one had received training in hand hygiene and two in relation to infection prevention and control.

16. 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:
Site specific protocols will be developed from the National Guidelines and regularly reviewed by the Person in Charge and Team Leader. The Person in Charge will ensure staff members are informed of local and organisational protocols and adhere to same. Training will also be scheduled for staff members in hand hygiene and infection prevention and control.

Proposed Timescale: 31/05/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records reviewed did not demonstrate that the fire drills were effective as in only two instances was it recorded how long it took to evacuate the building and how many residents were present at the time.

17. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
The Person in Charge and Team Leader will ensure all relevant information is documented with regards to fire drills in the Designated Centre. The Person in Charge will liaise with the Manager in charge of the Day Service to agree and ensure a consistent approach is documented in the records.

Proposed Timescale: 31/03/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence provided to inspectors of a review by COPE Foundation of the use of digilocks on doors that restricted people's ability to access their own personal living space.

18. 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:
The use of digilocks in the designated centre was to protect residents' privacy and reduce the possibility of clients from the adjacent day service accessing residents' bedrooms during the day. This practice is under review and the use of digilocks will be phased out as part of the over-all review in the management of the services provided in this designated centre.

Proposed Timescale: 30/04/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a system in place to Investigate any incident, allegation or suspicion of abuse. However, a residents' safeguarding plan did not demonstrate the steps to be taken following each and every allegation of abuse and how any required action would be completed.

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

Please state the actions you have taken or are planning to take:
The resident's safeguarding plan will be reviewed. It will clearly state who is responsible for ensuring that any recommendation or action will be implemented and reviewed accordingly.

Proposed Timescale: 29/03/2016

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:
A comprehensive assessment of residents' educational, employment and training goals was not available for all residents in order to ensure that the day service programme was suited to individual resident's abilities or to explore options for community-based training and employment (where applicable).

20. 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 and Team Leader will ensure all residents will have a comprehensive assessment of their educational, employment and training goals to ensure that the current day service programme is suited to individual resident's abilities needs.

Proposed Timescale: 31/07/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Overall, required healthcare checks were completed, such as monitoring of blood pressure, blood glucose levels and any seizure activity. However, some gaps were noted. The care plan did not provide direction as to when and how weights should be taken and recorded.

21. 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:
The Person in Charge and Team Leader will review all healthcare records to identify and amend any gaps identified. Weights will be recorded in residents' care plans using the Imperial weight system only. All staff informed.

Proposed Timescale: 31/03/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors noted a number of errors by staff in recording the administration of medication.

22. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered

as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
The Person in Charge has reinforced procedures with all staff members who administer medication to residents, including their responsibilities to adhere to medication management as per organisational and national policy. The Person in Charge will continue to monitor and regularly audit medication management compliance by staff.

Proposed Timescale: 31/03/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not have sufficient information in relation to:
• That the centre was only open on a five day basis from Monday to Friday
• The specific care and support needs the centre was intended to meet, for example the statement of purpose said the centre provided care to people with "intellectual disability and autism".
• How many respite beds were available in the centre

23. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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 statement of purpose will be amended and missing information will be provided.

Proposed Timescale: 30/04/2016

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 provider had ensured that unannounced visits to each house within the designated centre had been completed; the first in September 2015 and the second in February 2016. Inspectors reviewed the report arising from such visits and found that visits required development in order to meet the requirements of the Regulations. However, while some key aspects of quality and safety of care being delivered were reviewed, other aspects were not.

24. 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 or designate with appropriate management responsibility will complete the Annual review of quality and safety of care. A copy of the review will be available in the designated centre.

Proposed Timescale: 30/04/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Gaps were noted in relation to mandatory and training required to meet the needs of residents. One staff required training in relation to the management of behaviour that challenges and moving and handling and this had been scheduled by the person in charge. Training in infection control and hand hygiene had not been completed for all staff. In addition, an insufficient number of staff had received training in relation to the administration of emergency medication.

25. 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:
The person in charge will source training for staff in hand hygiene, infection control, and administration of emergency medication. Mandatory training is available all year and Person in Charge will schedule staff members on the appropriate courses. Two staff have attended training in relation to administration of emergency medicine 25/03/2016. Places have been booked on the next infection control course 12/04/2016 and MAPA 19/04/2016.

Proposed Timescale: 31/05/2016

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 residents' guide did not include the following items which are specified in the regulations: • The terms and conditions relating to residency • Arrangements for resident involvement in the running of the centre • How to access inspection reports • The procedure for complaints **26. Action Required:** Under Regulation 20 (1) you are required to: Prepare a guide in respect of the designated centre and provide a copy to each resident. **Please state the actions you have taken or are planning to take:** The residents guide will be updated to include missing information.
Proposed Timescale: 30/04/2016
Theme: Use of Information **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** - Inspectors saw that the communication diary contained a number of original hospital consultant out-patient appointment records stapled into the diary. This filing method could not guarantee the confidentiality of residents' personal information. In addition, it was not always clear if a plan of care for these identified healthcare needs was being developed prior to and following these healthcare appointments. -The filing system for healthcare records needed improvement. In one resident's healthcare file there were appointment records, reports of blood tests and consent forms all filed loosely in the back flap of the file. **27. 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:** This practice is no longer in place. Staff now record all hospital appointments in writing in the communal diary and the original appointment letter is kept at the front of residents' personal care plans. The filing system for healthcare records in residents' personal files has been amended.
Proposed Timescale: 29/03/2016