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-0003314
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Colette Fitzgerald
Lead inspector:	Carol Maricle
Support inspector(s):	Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
13 April 2016 09:00	13 April 2016 17:10

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was a monitoring inspection carried out to monitor the compliance of the centre with the regulations and standards.

How we gathered our evidence

As part of this inspection, the inspectors met with four adults who were recipients of respite care the evening prior to this inspection. The residents told inspectors that they were very happy with the service they received at this centre, they were comfortable, they felt safe and they enjoyed doing activities outside the centre such as going into the nearby town and eating out. They showed the inspectors around the centre and were positive about the staff that worked there, the food that was prepared for them and the activities they participated in at the centre which was to their personal taste such as watching their favourite television shows. They all had been in receipt of respite services for a number of years and all attended a day centre that was located nearby. The inspectors met with a relief staff member who was on shift on the morning of the inspection, the person in charge and a person nominated by the provider. Inspectors observed the staff member as they interacted with the residents. They reviewed a sample of policies and procedures and a range of other documentation such as personal plans, incident and accident logs and a selection of staff files.

Description of the service
The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. Inspectors found that the service matched what was described in that document. The centre was a purpose built five bedroom house and provided respite for four adult residents at any one time. Each resident had their own bedroom and there was communal space in the building both indoors and outdoors. The centre had access to local shops and to public transport. The service was available to 20 adult men and women who had a diagnosis of an intellectual disability and/or autism.

Overall judgment of our findings
Despite the positive review of the service given by the residents, inspectors were not satisfied that the provider had put systems in place to ensure that the regulations were being met and that adequate governance arrangements were in place. It was clear that the person in charge and the person nominated by the provider knew the residents very well and over a long period of time. However, there were insufficient arrangements in place to ensure that the person in charge was suitably supported to manage this centre given her other managerial responsibilities within the organisation. Inspectors found that there was a lack of governance and clinical oversight of the service compounded by a lack of written evidence of the care provided to residents.

The inspectors found that the lack of effective governance and management systems had resulted in:
- risks not being identified in health and safety due to poor risk management procedures (outcome seven)
- lack of robust safeguarding systems due to insufficient record keeping (outcome eight)
- lack of robust supervision of staff (outcome 17).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.

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 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:
Despite a number of positive practices at the centre in the area of social care needs, the provider was not meeting the required standards and regulations. Residents had opportunities to take part in meaningful activities and were supported in coming to and from the centre. The arrangements for staff to meet the needs of the residents were set out in personal plans that reflected their needs and wishes but there was insufficient evidence to show that these personal plans were made available to residents. Residents' wellbeing and welfare was potentially compromised due to inadequate arrangements for recording their on-going needs as required to reflect changes in such needs and circumstances.

Personal plans were developed for the residents but improvements were needed. As the residents were recipients of services prior to the commencement of the regulations, there were no formal assessments conducted within 28 days of their first admission for respite. However, each resident had a personal file that outlined their health needs, personal care and support needs. There was no date on the personal plan therefore it was not possible for inspectors to ascertain the version date and whether the plan had been reviewed. The plan was written in an accessible way for residents and the residents with whom inspectors met had some awareness that they each had a personal plan but they did not know how to access a copy. There was no evidence to suggest that they and/or a representative were involved in a review of their plan. Overall, there were insufficient day to day records written by staff to demonstrate how they supported the residents during their stay at the centre. This meant that there were no records to show how staff may have helped the residents to achieve life skills and goals relevant to their respite stay.

Residents had opportunities to take part in meaningful activities but the recording of this was insufficient. There was sufficient information in personal plans that would guide staff on their interests and likes/dislikes. The inspectors met four residents who had come for respite the night before the inspection and all four residents were very happy with the range of activities that they were involved in at this centre. Some told the inspectors that they enjoyed using their phones and watching television. Residents also frequented local restaurants and shops. It was clear to inspectors that the residents considered their respite as a part of their normal routine alongside their attendance at a local day centre. They used words such as 'relaxing' and a 'break' and they were very comfortable in the surroundings of the centre. Staff kept activity records for each resident and these set out very briefly the activities that each resident participated in each day. Some activity sheets were not dated or signed and there was no evidence of quality assurance of these documents. The inspector did not find completed activity sheets for all periods of respite.

The relief staff member on duty was warm and pleasant in her approach to the residents and knew them well as she also worked in the day centre that they attended. While it was her second time working at the centre however, inspectors noted that she had not received a formal induction to the centre and was therefore not adequately familiar with a number of aspects of residents' personal plans.

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:
Overall there were improvements needed in how the health and safety of residents and staff was protected by systems at the centre.

There were systems in place to manage risk but the practices required improvement. The centre had a suite of policies for staff to follow in areas such as risk management, the reporting of accidents and incidents, fire safety, missing persons and transporting residents. The centre had a health and safety statement. There were no training records available for the inspectors to review. The staff member on duty told inspectors that she had not received training in moving and handling or fire safety. The risk management policy although comprehensive did not contain all aspects of risk management that were required in the regulations for example, it did not set out the measures and actions in

place to control the unexpected absence of a resident, the risk of aggression and the actions to control the risk of injury. An audit of health and safety was carried out at the centre in 2015 but it did not contain a written report on findings and it did not outline learnings for staff.

Hazards particular to this centre were not identified. A set of hazards identified at a nearby designated centre (under the auspices of the same provider) was presented to inspectors as the risk register for this centre. This was not accepted by the inspectors as it was not individualised to this centre and contained information on controls that were not in place. Hazard identification was therefore inadequate as inspectors noted potential hazards that had not been identified or risk assessed. This included window restrictors not in place in the upstairs windows and an upstairs landing that was at a considerable height to the ground floor and may pose a risk to residents in the event of a fall. An inspector found broken tiles in a bathroom which had not been removed and was thus a hazard. There was a considerable gap between the fire doors in the kitchen and the accompanying door frames which had not been risk assessed as to the impact this would have on the effectiveness of the door to contain a fire.

There were no individualised risk assessments in each of the personal files of the residents. This was concerning as it meant that staff may not have all of the information they need when making decisions about the care and support they were giving residents. It was not clear if residents were able to leave the centre of their own accord and to walk to the nearby town which was a few minutes walk away. Some residents told the inspectors that they were 'allowed' and some said that they were 'not allowed' as they had not received training in the area of road traffic. There was some reference in the residents' personal plans to their need for supervision but no further information.

There were systems in place to guide staff on the recording of incidents and accidents, however, inspectors noted that there was inadequate incident and accident recording for example, an inspector reviewed a record of aggression by a resident towards another but there was no incident record to cross reference this event with. There were no incidents or accidents recorded by staff to have taken place in the 12 months prior to the inspection.

There was no maintenance book kept by staff rather it was the practice that maintenance issues were recorded by staff in an office diary. It was therefore difficult for inspectors to identify if matters were addressed or still outstanding.

Some infection control measures were in place but improvements were required. There were a number of appropriate procedures in place for the prevention and control of infection, such as ready access to hand-washing and sanitising gel for visitors. The centre was clean. Cleaning duties were attended to by staff but there was no cleaning schedule to guide staff. There was some use of communal toiletries which in some instances was not hygienic.

There were fire safety management systems in place but improvements were required. There were evacuation procedures displayed throughout the centre. Fire exits were clear. Extinguishers had been serviced in the twelve months prior to the inspection. The fire alarm system and emergency lighting had been inspected regularly by an external

company. Fire checks were completed by staff but there were gaps on some days and this were not explained. There was a fire register but the front page details were not recorded therefore it could not be assured that this register was the register for this centre. Essential information such as the telephone number of the emergency services was not completed.

Fire drills had taken place in the 12 months prior to this inspection, however the time of the day that the drill took place was not recorded. The residents that were there on the day of the inspection told inspectors that they had taken part in fire drills but not at this centre. Personal emergency egress plans (PEEP's) had been completed and a number of residents had been identified as requiring assistance in the event of a fire evacuation. However, for residents requiring this assistance inspectors noted that their PEEP did not record any assistance or contingencies to address these identified evacuation needs.

CCTV systems were used in the outside areas but there was no signage to alert visitors to the use of same.

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

Findings:
Measures to protect residents from being harmed or suffering abuse were not sufficiently in place at the centre. There was a lack of written evidence to show that residents were provided with emotional, behavioural and therapeutic support.

There was an organisation policy in place for the management of allegations of abuse but staff, including the person in charge had not yet completed training on the new safeguarding policies published by the health service executive in 2015. There had been no concerns according to the person in charge that required reporting to the health service executive or HIQA in the 12 months prior to the inspection. Residents told inspectors that staff treated them with respect and were kind towards them. Inspectors observed a staff member interacting with the adults in a respectful manner treating

them with kindness and warmth. The intimate care needs of adults were assessed as part of the personal planning process and intimate care plans were in place. Overall, however, there was insufficient record keeping completed by staff which meant that the experience of residents during their respite stay was not fully accounted for. This meant that it was difficult for the person in charge to assure herself that adults were kept safe and well during their stay as there were no comprehensive records for her to review.

There was a lack of written evidence to show that staff supported residents pro-actively when they engaged in behaviours that challenged. There were no training records available to inspectors to review in this regard. The person nominated by the provider had visited the centre in 2015 and a report of this visit confirmed that relief staff needed training in the management of actual and potential aggression. The inspectors viewed evidence of guidance developed by specialists in a personal file on how to best to respond to various behaviours that challenged. It was not possible to ascertain if the guidance was being followed by staff as written records in this regard were not kept. Inspectors viewed some records which outlined the strategies used on occasion with one resident but these strategies were not agreed in writing with the resident, and/or their representative and/or a behaviour specialist.

A restraint free environment was promoted at the centre as doors were generally unlocked and residents could come and go as they please throughout the house and rear garden. The person in charge told the inspector that there were no restrictive practices of a physical nature used at the centre by staff but there was no written evidence to support this.

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:
There were systems in place to support the residents achieving and maintain their health and well-being whilst on respite however, improvements were required.

The healthcare needs of residents were assessed through the personal planning process but improvements were required as there was minimal written records confirming that identified needs were being met by staff. The service provided in this centre was a respite service therefore, emergency medical treatment was facilitated by staff with the

expectation that the residents day to day medical needs were attended to at their normal place of residence. Overall, there was sufficient information to help a staff member understand the healthcare needs of the residents upon their arrival to the centre. There was reference to the health of the residents in their personal plan in areas such as allergies, their diet and their medical history. Residents had hospital passports that would help healthcare professionals understand their needs in the event of a healthcare emergency. However, it was concerning that the relief staff member on duty on the day of the inspection had not received an induction. This meant that she was not shown the residents' personal plans that set out their healthcare needs. On a day to day basis, there was insufficient recording by staff to indicate that the healthcare needs of residents were met and there was no evidence to suggest that residents were encouraged to take responsibility for their own health and medical needs.

The recording of nutritional intake was insufficient. The recording of the nutritional intake where residents had special dietary needs was not sufficient in order to assure the person in charge that the dietary needs were being taken into account by staff involved in food preparation. On occasion, the nutritional intake of a resident was written in to the communal staff diary which was not a suitable recording mechanism.

Residents told inspectors that they were offered a choice of evening meals but they did not participate in the preparation of the evening meal. They were not sure why this was the case, citing that thought that it may not be safe. Others told inspectors that they were able to make tea and toast by themselves. There was insufficient evidence to show that residents were supported to buy, prepare and cook their own meals if they so wished.

Judgment:
Non Compliant - Moderate

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:
Medication management systems were in place to protect the residents but there was a lack of local protocols which meant that the system was not robust.

There was an organisational policy in place relating to the prescribing, storing and administration of medicines to residents and inspectors viewed a sample of medicine management practices. The policy made reference to services that provided 'short

breaks' such as this service and referred the reader to local protocols, however, there were no such protocols in place. Given that the nature of the service was respite there was a flow of medication in and out of the centre each day and the procedures to receive, document and account for medicines in this regard were not clearly identified. There were no staff training records kept at the centre for the inspectors to review. The relief staff member was not trained in medication management and was instead supported by a staff member from a nearby designated centre for adults (under the auspices of the same provider) who would come to the centre at the required times to administer medication. This arrangement was not written down nor risk assessed by the person in charge. It was not clear what the arrangements were should the staff member be otherwise occupied at their usual place of work. The system of relying on staff working at other centres to administer medication was fraught with risk and had not been identified as a hazard in a formal capacity. The person in charge acknowledged that there was a need to have the relief staff trained in medication management.

The inspectors reviewed a sample of medicine prescription and administration records for residents however, there were only a small number of these records available for the inspectors to review. The person in charge told the inspector that these records were kept by the resident at their usual place of residence and when they arrived for respite they brought the records with them. These arrangements were not set out in policy and this also meant that the person in charge could not review or audit these records at any one time as they were generally kept off-site.

A small sample of the records were viewed by inspectors. Some of the 'as required' medicines on the prescription records had no start date recorded. This meant that there was a risk that these medicines might be inappropriately administered. The name of the general practitioner was not stated on the prescription record, although their signature was written on the form. The administration of medicine against what was prescribed required improvement. There was no space for the staff member to write details in the event that a resident refused medication. The initials of the staff member were not accompanied by a signature sheet. Some administration records had the letter 'h' recorded which according to the person in charge meant that the resident had taken this medication at their home however this had not been verified. The person in charge acknowledged that the systems at the centre needed to be supported by local procedures.

At the time of the inspection, the person in charge told the inspectors that were no adults in receipt of the service who were prescribed controlled drugs, therefore a separate safe to store this type of medication was not needed. There was some medication found in the medication safe by the inspector that required disposal and this was attended to immediately by the person in charge.

Some residents told inspectors that they took their medicine at home by themselves and without support but they did not self administer at this centre. Residents told inspectors that they thought it might be due to safety reasons. There was no evidence that their needs in this area were assessed through the personal planning process.

Judgment:
Non Compliant - Moderate

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:
There was a clearly defined management structure that identified the lines of authority, accountability and responsibility for the provision of service. However, despite these arrangements, the quality, care and experience of the residents was not sufficiently monitored and developed on an on-going basis. Effective management systems were not in place to support and promote the delivery of safe, quality care services.

Management systems were in place but these systems were not supported in full by effective evidence based care and practices at the centre. An annual review of the service had not been completed in 2015. The person nominated by the provider told the inspectors that she had visited the centre on one occasion in 2015 in an unannounced capacity and a record of this visit was maintained. However, there was no formal feedback requested by the provider from the residents and/or their representatives. The record of the unannounced visit was not sufficient in guiding the provider on the quality and safety of care that residents received at this centre. She provided to the inspectors a copy of the annual review template that was to be used at the centre for 2016. This included a prompt for those conducting the review to ascertain the views of residents.

At the time of this inspection, there were no formal audits, other than a health and safety audit conducted in October 2015, that had been completed at the centre in the 12 months prior to the inspection. There were no comprehensive records kept of the day to day experience of the resident whilst on respite, this meant that the quality of the care given by staff and the experience of the residents could not be monitored through written evidence. The staff were not supervised in a formal manner and wider systems of performance management and development systems were not in place at provider level. Verbal handovers were completed by staff when they handed the keys of the centre to the person in charge who worked at a nearby centre.

The arrangements for on call were not displayed in the staff office nor on a roster rather the details were contained in a folder and not easily retrievable for staff to use in an

emergency. There were informal on call arrangements where staff sought support from colleagues who worked at a nearby designated centre however, these process were ad hoc and not structured or recorded.

There were no staff team meetings held at the centre. The person in charge acknowledged that this would be rectified going forward. Staff used an office diary which set out some basic information on the shift that had taken place and some instructions for staff for following shifts. This information included personal information on the residents, maintenance issues and other notes. It was not a suitable method for staff to communicate issues with each other about the residents and the records were not quality assured by the person in charge.

The centre was managed by a suitably qualified person in charge however, the arrangements for the person in charge to manage this centre were inadequate as she managed three designated centres in total and was part of the core staff providing resident care and support in one of these centres. She also had some managerial responsibilities for a day centre. She told inspectors that this meant that she did not have the time to effectively govern this centre. She visited this centre during work hours and on occasion in her own personal time. She did not receive a formal induction to the role of person in charge upon her appointment but meets with her line manager once a month and they speak regularly by telephone. She told inspectors that she felt supported by her line manager. She was committed to her professional development and had completed some continuous professional training in the 12 months prior to the inspection.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Overall, the arrangements regarding the workforce were not sufficient and did not meet the regulations. There were appropriate staff numbers rostered to meet the needs of the residents. Personnel files were mostly in compliance with the regulations. Residents received continuity of care from a core staff team. There were no records of training

available for inspectors to review. Not all relief staff were trained in core areas such as fire safety, manual handling and medication management. There were no appropriate systems in place for the day to day or formal supervision of staff.

There were sufficient numbers of staff to meet the assessed needs of the residents but the experience of staff was on occasion not suitable. The staff ratio was one member of staff to four residents which on the day of the inspection was suitable. The same staff member generally slept overnight at the centre and worked a number of hours the following morning. Residents received continuity of care from two permanent members of staff who had considerable experience of working with the residents and when they were not rostered to work the person in charge organised for relief staff to work at the centre. As the staff ratio was one member of staff to four residents, this meant that relief staff worked alone at the centre. On the day of the inspection, the relief staff member had worked at this centre only on one previous occasion. She knew the residents very well as she worked with them at the day centre which was under the auspices of this provider.

The person in charge showed an inspector the staff roster for a sample of weeks, including past, current and forecasted schedules. The roster did not show the actual hours that staff were expected to work, for example, staff were described as working until 10.00pm and then doing a sleep over but it did not state that the same staff member also worked a number of hours the following morning. It was not clear when a staff member did not complete their shift as planned. The person in charge told inspectors that there were no systems in place to record the actual hours that staff members worked.

There were gaps in training. There were no training records available for the inspectors to review on the day of the inspection. The staff member on duty had not received training in fire safety, manual handling or medication management.

Supervision systems were not in place at the centre. There was an organisation policy on supervision but supervision was not provided to staff in practice. Staff were not supervised in a formal capacity at the centre nor were they supervised on a day to day basis. This meant that staff did not have an opportunity to reflect on their practice and to identify learnings and developmental needs. There was no wider performance appraisal system within the organisation.

Inspectors viewed a sample of personnel files and they were found to mostly meet the needs of the regulations. Inspectors viewed the office diary and saw records of a volunteer working at the centre. The person in charge confirmed that she was a student on work placement. Inspectors viewed her file and it did not clearly set out the expectations of her role and to whom she reported to.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
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Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003314
Date of Inspection:	13 April 2016
Date of response:	17 June 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The residents did not know how to access a copy of their personal plan.

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

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

representatives.

Please state the actions you have taken or are planning to take:
The PIC will ensure all residents are informed of where their personal plans are kept. Appropriate easy read signs will be put in place to inform residents.

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:
The personal plans for the residents failed to show how the resident and where applicable their representative had contributed and participated to the development of the plan.

2. 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:
An action plan will be put in place to review and update all personal plans of people availing of respite. The plans will focus on the residents' goals and activities during their stay and will be developed with staff from the relevant day centre, members of the multi-disciplinary team, the resident and their family/advocate.

Proposed Timescale: 30/10/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to show that the effectiveness of the personal plans had been assessed and that changes in circumstances and new developments had been identified.

3. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
The PIC will ensure that all personal plans are updated and that an annual review system is put in place.

Proposed Timescale: 30/10/2016

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:
Not all hazards were identified and risk assessed at the centre.

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

Please state the actions you have taken or are planning to take:
HIQA 3-day and quarterly notifications are reviewed on an on-going basis by the PIC. In addition incident reports are reviewed 3 monthly, potential hazards are identified and the Risk Register is updated with controls put in place.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not set out the measures and actions in place to control the unexpected absence of a resident.

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

Please state the actions you have taken or are planning to take:
Staff members will focus on the recommendations of the organisations "Policy and Procedure on Missing Persons", using the positive risk assessment tool. All residents on respite will have their plans updated. If a person is known to wander or abscond an individual response plan will be included in their support plan.
The Risk Management policy is now adapted to include unexpected absences, accidental injury and risk associated with aggression and violence

Proposed Timescale: 30/08/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not set out the measures and actions to control accidental injury to residents, visitors and staff.

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

Please state the actions you have taken or are planning to take:
The organisations risk management policy will be followed and the PIC will review local protocols to reduce risk. Controls will be put in place by updating the Risk Register, the accident reporting book and visitors book will be updated and the fire register. Local protocols in case of accidents/incidents and emergencies will be put in place.
The Risk Management policy is now adapted to include unexpected absences, accidental injury and risk associated with aggression and violence.

Proposed Timescale: 30/08/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not set out the measures and actions in place to control the risk of aggression and violence.

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

Please state the actions you have taken or are planning to take:
The PIC will review the existing Positive Behaviour Support Plans for residents on respite. Agreed plans on interventions and strategies in response to an episode or incident will be documented. The local risk register will be updated to reflect the matrix of residents on respite. Residents on respite who do not have a PBS plan in place will have their support plan reviewed.
The Risk Management policy is now adapted to include unexpected absences, accidental injury and risk associated with aggression and violence.

Proposed Timescale: 30/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no cleaning rotas in use at the centre which meant that the person in charge could not be assured that the centre was cleaned daily by staff.

8. 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 cleaning rota to ensure effective levels of hygiene with a tick box and signature requirement will be put in place which can be reviewed easily by the PIC.

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in the fire precaution records and they were not explained.

9. Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
• The Fire Register will be updated to comply with standards.
• Staff members will ensure that regular fire drills are carried out in the respite centre.
The PEEPs for each person availing of respite will be audited to ensure that the correct level of assistance is given to each person.
A recording sheet is now in place to record daily Fire Drills with spaces for explanation of when centre is closed Fire Drill is not completed.

Proposed Timescale: 31/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to show that the provider had ensured that all residents were aware of the procedure to be followed in the event of a fire.

10. 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:
• A plan will be put in place to ensure all respite users are aware of the procedure to be followed in the event of a fire and this will be documented in their PEEPs.
• Basic fire training in fire safety will be put in place for residents on respite.
• Staff members on duty will discuss the fire evacuation plan with the resident as soon as possible after they arrive for respite.
• Fire drills will be carried out at least fortnightly/when open.

Proposed Timescale: 30/08/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to show that staff had up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

11. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
PBS plans are reviewed by a Behavioural Specialist. MAPA training is scheduled for staff members on 8 and 9 August 2016. Staff members will review the PBS plans for each respite resident and familiarise themselves with the plans. HR records will be updated and 1 day refresher courses scheduled.

Proposed Timescale: 09/08/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where therapeutic interventions regarding challenging behaviour were designed there was no evidence that these were reviewed as part of the personal planning process or agreed with the resident and/or their representative.

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

Please state the actions you have taken or are planning to take:
Staff members from the day centre, where residents attend daily during the week, contribute to the review of the PBS plans in conjunction with the Behavioural Specialist, as they are familiar with residents in the short-break centre.
Updated PBS plans will be documented with families and the individual and will be updated to the respite centre.

Proposed Timescale: 30/10/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient written evidence to show that staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Please state the actions you have taken or are planning to take:
Safe guarding training was arranged and delivered for relevant staff members. All training records have been updated by HR.

Proposed Timescale: 29/04/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The healthcare needs of residents was outlined in their personal plan but there was insufficient written evidence to show that staff addressed their day to day healthcare needs.

14. 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 PIC will reinforce the importance of completing and updating records with staff members. Staff will complete records to show the care and support given to residents when they are availing of respite at the centre.

Proposed Timescale: 31/07/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to show that residents were supported to buy, prepare and cook their own meals if they so wished.

15. Action Required:
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

Please state the actions you have taken or are planning to take:
Staff members will prepare meal plans with respite residents and facilitate residents to prepare meals if they wish. Staff members and residents will shop together to purchase ingredients. A system to capture this activity will be developed by the PIC.

Proposed Timescale: 31/07/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient written evidence to show that the food and drink given to residents with special dietary needs was consistent with their dietary needs and preferences.

16. Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
A meal plan will be developed to capture each person's dietary requirements and preferences while on respite. The meal plan will be displayed in an easy read version in the kitchen area. A recording sheet is available for staff to complete when it is necessary to keep a record of food and fluid intake for a resident.

Proposed Timescale: 31/07/2016

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:** There was no evidence to suggest that residents were assessed as to their capacity to take their own medication and encouraged in this regard. **17. Action Required:** Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability. **Please state the actions you have taken or are planning to take:** An individual risk assessment will be completed with members of the inter-disciplinary team to support individuals who wish to self-medicate when on respite. A self-administration plan will be developed and reviewed if the respite resident has the capacity to self-medicate. The plan will be re-evaluated as residents needs and circumstances change.
Proposed Timescale: 30/09/2016
Theme: Health and Development **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** There were no local protocols in place which was not in line with the organisation policy. **18. 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 PIC will arrange for a robust system to manage the transfer, receipt and storage of respite resident's medications during short-break stays in line with the organisations Policy and Procedures of the Administration of Medication.
Proposed Timescale: 30/08/2016

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 person in charge managed three designated centres and also had managerial responsibilities for a day centre. She told inspectors that she did not have the time to manage this centre effectively given that she was not supernumerary to the rosters. She visited the centre in her role as person in charge on occasion outside of her scheduled hours. **19. Action Required:** Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents. **Please state the actions you have taken or are planning to take:** A plan was submitted to the organisations funding body, seeking extra staffing to allow for the PIC to manage the centres under her charge more effectively. To date no funding has been approved. A review of the role of the PIC has taken place to ensure that she is given support to manage the centre. Following the monitoring visit by HIQA on 13/03/2016 the Provider Nominee has held a number of meetings with the PIC onsite and off-site to address concerns in relation to support. An annual review was carried out on the 26/05/2016 by a person delegated by the Provider nominee. In addition the Provider nominee carried out an unannounced visit on 29/06/2016. Action plans were developed and review dates are in place. The PIC is now supernumerary and is no longer filling gaps in the roster, which enables her to fully supervise the 3 centres. She will have a daily presence in the 2 adjacent centres and visit the 3rd centre weekly, with daily telephone contact. She has scheduled staff meetings for the 3 centres. A plan is to be put in place to transfer the responsibility and Management for the adjacent Day Centre to another Division in Cope Foundation over the coming months
Proposed Timescale: 30/08/2016
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** There were insufficient management systems in place at the centre. **20. Action Required:** Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
A plan was submitted to the organisations funding body, seeking extra staffing to allow for the PIC to manage the centres under her charge more effectively. To date no funding has been approved.
A review of the role of the PIC has taken place to ensure that she is given support to manage the centre. Following the monitoring visit by HIQA on 13/03/2016 the Provider Nominee has held a number of meetings with the PIC onsite and off-site to address concerns in relation to support.

An annual review was carried out on the 26/05/2016 by a person delegated by the Provider nominee. In addition the Provider nominee carried out an unannounced visit on 29/06/2016. Action plans were developed and review dates are in place.
The PIC is now supernumerary and is no longer filling gaps in the roster, which enables her to fully supervise the 3 centres. She will have a daily presence in 2 adjacent centres and visit the 3rd centre weekly, with daily telephone contact. She has scheduled staff meetings for the 3 centres. A plan is to be put in place to transfer the responsibility and Management for the adjacent Day Centre in Fermoy to another Division in Cope Foundation over the coming months.

Proposed Timescale: 30/07/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the service for 2015.

21. 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 carry out unannounced visits as required and document. An annual review was completed in May 2016 and documented and an action plan developed.

Proposed Timescale: 19/07/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no formal supervision given to staff. There were no performance management development systems at the centre.

22. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
A Performance Management System is in place, however reviews need to be completed for staff members in this centre and this will be scheduled.

Proposed Timescale: 30/06/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider did not carry out two unannounced inspections of the centre in 2015 that addressed the safety and quality of care and support that was provided to residents.

23. 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 6 monthly unannounced visits as required and document.

Proposed Timescale: 30/07/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The skill mix of some of the relief staff was not sufficient to ensure that they were able to perform all aspects of their role.

24. 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:
The PIC will review the staff rota and ensure the training and skills of all staff members, including relief staff, are appropriate and up to date.

Proposed Timescale: 30/09/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff roster maintained at the centre was inaccurate.

25. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
The PIC will review and update the staff rota to reflect the actual times on duty for day and night for staff staying in the house.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to show that permanent staff were appropriately trained. The relief staff used at the centre did not have the training they needed in order to carry out their role sufficiently.

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

Please state the actions you have taken or are planning to take:
The PIC will review gaps in staff training with HR department and schedule training and refresher training as required. An action plan will be put in place.

Proposed Timescale: 30/09/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an insufficient supervision system in place.

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

Please state the actions you have taken or are planning to take:
The Provider Nominee and the PIC will meet with staff members in the respite centre to review and clarify their responsibilities in relation to compliance with the regulations. The PIC will put schedules in place to visit the centre on a regular basis and on an unannounced basis.

An annual review was carried out on the 26/05/2016 by a person delegated by the Provider nominee. In addition the Provider nominee carried out an unannounced visit on 29/06/2016. Action plans were developed and review dates are in place.
The PIC is now supernumerary and is no longer filling gaps in the roster, which enables her to fully supervise the 3 centres. She will have a daily presence in two centres and visit the 3rd weekly, with daily telephone contact. She has scheduled staff meetings for the 3 centres.

Proposed Timescale: 31/07/2016