

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cork City North 2
Centre ID:	OSV-0003696
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Colette Fitzgerald
Lead inspector:	Julie Hennessy
Support inspector(s):	Niall Whelton
Type of inspection	Unannounced
Number of residents on the date of inspection:	13
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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
20 June 2016 09:00	20 June 2016 16:30
21 June 2016 09:00	21 June 2016 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the second inspection of this centre in response to an application by the provider to register the centre. The purpose of this inspection was to determine the level of progress made since the previous inspection in addressing key areas of quality and safety of care and support provided to residents in the centre.

Description of the service

The centre is part of COPE Foundation's community residential services for adults with an intellectual disability. The centre comprises two residential houses located in a city suburb. The first house is a dormer bungalow and can accommodate seven residents. The second house comprises two semi-detached houses over two floors, between which access had been created to allow shared kitchen/dining/living space and free movement between both houses. This house can accommodate six residents.

Both centres provided respite services from existing accommodation i.e. for which there were no additional facilities in the form of extra beds or bedrooms.

How we gathered our evidence

Inspectors met seven residents who lived in this centre and were briefly introduced to two other residents. Residents with whom inspectors spoke said that they were happy with where they lived and told inspectors about what they enjoyed doing, where they enjoyed going, their friends and family. Residents who were non-verbal were supported to communicate their choices and wishes via their preferred means of communication.

Inspectors also met the representative of the provider, team leaders, members of the staff team and a student and trainee on placement over the course of the inspection. The team leaders were registered nurses in intellectual disability nursing and had been identified as persons participating in the management of the centre. The person in charge of the centre was not present at this inspection.

Overall judgment of our findings

Overall, the inspector found that number of actions had been completed since the previous inspection. Completed actions included ensuring residents and/or their representatives were aware of how to make a complaint, that personal plans were in an accessible format and that respite arrangements were cognisant of privacy, dignity and infection control challenges.

However, two outcomes remained at the level of major non-compliance since the previous inspection with further findings relating to the accessibility of the centre. The fire and estates inspector assessed fire safety management arrangements and found that they were not adequate. In addition, there were failings relating to accessibility of the premises. Under Outcome 6: Safe and suitable premises, neither house was fully accessible for residents who lived there. In particular, where resident(s) were wheelchair users, toilet/shower facilities in one house were not accessible and communal areas of the house could not be freely accessed by all. Under Outcome 7: Health, safety and risk management, arrangements in place for the containment of smoke and fire were not adequate as fire doors were not installed where required throughout the centre.

Other actions required further improvement, such as reviewing the effectiveness of personal plans, risk assessments and monitoring the governance of the centre.

Findings are discussed in the body of this report and required actions to be taken to address any non-compliances are outlined in the action plan at the end of this report.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Overall, actions required from the previous inspection had been satisfactorily implemented. While residents' bedrooms were still used to provide respite for other residents, steps had been taken to minimize the impact of this practice on residents who lived in the centre.

At the previous inspection, it was found that the use of residents' bedrooms for people accessing the service on a respite basis did not ensure each residents' privacy and dignity was being respected. Since the previous inspection, written permission was received to accommodate respite in residents' bedrooms from residents and/or their representatives. A protocol was developed that outlined how residents' personal possessions will be secured, how monies will be stored safely, how infection control considerations, residents' healthcare and intimate care needs will be met. From speaking with staff and a review of a sample of respite forms, it was demonstrated that the protocol was being implemented in practice.

At the previous inspection, it was found that the complaints procedure on display did not identify a nominated complaints officer. Since the previous inspection, the inspector observed that all complaints posters on display within the centre now have the name and contact details of the Cope Foundation Complaints Officer. In addition, a easy to read version of the complaints poster had been developed, was on display and the procedure had been explained to residents and their representatives.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

Aspects of this outcome were included as identified over the course of the inspection. Improvements were required to ensure that individual communication supports were clearly outlined in each resident's personal plan.

Staff were observed to support residents to communicate. Pictorial information and choice cards were used to support choices around activities, meals, outings and household tasks. Where residents had communication needs, a specific and individual communication profile had been completed that included for example, what each individual likes to talk about, their preferred means of communication and how needs and wishes are communicated. Input from a speech and language therapist (SALT) had been provided.

A staff member had recently completed a training course to support residents who used LAMH (an Irish manual sign system) as part of their preferred means of communicating. A number of other staff had completed modules of LAMH training previously. Staff told the inspector which LAMH signs residents used. However, this information was not specified in each resident's communication profile or communication of needs document to ensure that residents were supported to communicate at all times. A new format of communication passport (a person centred communication booklet to support individuals with communication needs) was being rolled out in one house for residents who were non-verbal, but not in the second house.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Overall, improvements had been made in relation to the setting of personal goals for residents. However, further improvement was required in relation to ensuring that all residents' needs were adequately assessed and in relation to the review of the personal plan.

Where residents were wheelchair users it was not demonstrated that an assessment by a suitably qualified person had been completed so as to ensure that the centre met that resident(s) needs in terms of accessibility. The evidence to support this finding is outlined under Outcome 6: Safe and suitable premises.

At the previous inspection, it was found that personal plans were not in an accessible format. In addition, consultation with families was not recorded in personal plans. Also, the supports required to achieve outcomes, such as resources and responsibilities, were vague and non-specific.

At this inspection, the inspector reviewed a sample of personal plans in both houses. A more accessible format of each plan had been developed for each individual resident since the previous inspection.

Personal plans were within their review date and contained information specific to each person, including people important in their lives, likes, dislikes and personal preferences. Personal plans were supported by other relevant information contained in health management plans, risk assessments, activity timetables, an assessment of self-help skills, behaviour support plans and communication profiles. A new format had been developed to capture and track goals more clearly. The new format included short-, medium- and long-term goals, who was responsible for supporting residents to achieve each goal and the steps involved in meeting each goal. Sample goals related to pursuing interests and hobbies (such as attending a concert), supporting independence (such as shopping unsupervised) and supporting friendships with peers of similar age and the same gender.

However, improvements were required in relation to both the personal plan itself and the review of the personal plan. A record of who had been involved in the development of each plan was maintained for some, but not all, personal plans. An assessment of residents' personal development needs and preferences had not been completed. As a result, it was not demonstrated that residents' goals as they related to how they spent their day were based on a comprehensive assessment. This will be further discussed under Outcome 10: General welfare and development.

In addition, the review of the personal plan did not meet the requirements of the regulations. The review of the personal plan was not multidisciplinary as required by the regulations. Where the staff nurse outlined that members of the multidisciplinary team had attended reviews for some residents, this was not documented. Also, discussions around key issues or challenges for residents were not always documented. Where gaps relating to service provision or supports were identified that could not be addressed by the staff team in the centre (e.g. in relation to the provision of a suitable day programme), an adequate action plan was not in place to address these issues. As a result, it was not demonstrated how the effectiveness of the personal plan was assessed.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

Some actions had been completed since the previous inspection as they related to providing a safe and suitable premises. However, other actions were outstanding and this report emphasizes additional failings relating to accessibility of the centre.

In one house, improvement works had been completed in toilet/shower room since the previous inspection including the installation of a new extractor fan and painting of the ceiling. However, a damaged shower chair seat required replacement. Staff told inspectors that a new seat had been ordered by the occupational therapist.

Also in this house, inspectors found that the toilet/shower facilities were not accessible to all residents and posed difficulties for any resident who was a wheelchair user. The inaccessibility of the toilet/shower facilities compromised residents' dignity, privacy and posed infection control and fall risks. For example, the toilet/shower room was confined in space and lacked hand rails and grab rails. Staff described how the toilet bowl and shower door may at times have to be used as a physical support by resident(s), presenting risks in terms of infection control and falls. Also, the design and layout of the toilet/shower room meant that the door to this room could not be closed when accessed by any resident who is a wheelchair user. In addition, there was no clear space towards the leading edge of the door on the pull side of the door, as would be required under best practice, to allow a person using a wheelchair to independently manoeuvre through the door. There was a utility room leading off the toilet/shower room into a living room and the door to this room was closed instead when the toilet/shower room was in use. There was no privacy lock on this door. In addition, the fire door between the kitchen and living room of this house was not held open by an appropriate mechanism. As a result, resident(s) who are wheelchair users were observed to have difficulty opening this door independently.

In both houses, access to the rear garden which was used by residents was not accessible to all residents. In the same house as discussed above, inspectors observed thresholds at external access doors, which could not be manoeuvred independently by resident(s) who were wheelchair users. In addition, following the previous inspection, ramps had been created at external access doors to replace steps that had previously been in place. However, the gradient of some of the ramps were observed to be steep and staff confirmed that they could not be manoeuvred independently by resident(s) who were wheelchair users.

In the other house, annual health and safety audits had identified sequentially that the rear garden needed to be levelled to address steps and an open edge in that space and make this an accessible space for all to use. The same audit also identified the need to replace a number of window frames that were old and damaged. The timeframe to complete this action from the previous inspection was 31 December 2016 and has not yet passed and so will be included again in this report to allow for tracking of this action. Inspectors observed that the roof windows at first floor required cleaning as there was a build up of grime externally.

Judgment:
Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

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

Findings:

At the previous inspection an immediate action plan was issued with respect to fire safety in one unit and in response, a fire safety assessment was completed by a competent person. In the other unit, recommendations of a fire survey report from June 2014 had not been fully implemented. In addition, gaps in fire safety training were identified. At this inspection, compliance with fire safety regulations was assessed by the fire and estates inspector.

With respect to the centre from a fire safety perspective; the designated centre comprised two dwellings situated in close proximity to each other. The first house inspected was in the form of a dormer bungalow accommodating seven residents. There were four bedrooms on the upper floor, with three bedrooms on the ground floor. Further accommodation included two bathrooms for residents, a kitchen, dining room, living room, utility room, office and staff toilets. The second house consists of two semi-detached dwellings combined together to form one dwelling, accommodating six residents. The ground floor is connected by way of a door between the dining room and rear living room. There is no connection at first floor with a stairs on each side of the house serving the first floor. Accommodation in the second house consisted of six bedrooms for residents, one of which was on the ground floor, kitchen, dining room, living room, visitors room, utility, staff office and toilets and two bathrooms for residents use. Inspectors were informed that staff do not sleep while on duty.

The action with regard to the recommendations of a fire survey report from June 2014, identified on a previous inspection had not been addressed. The inspector found, in each dwelling, that the building was not adequately separated by construction resistant to the passage of fire.

The inspector reviewed the fire safety management practices in place, including the physical fire safety features of each building. The inspector also examined records for maintenance, fire safety training of staff, evacuation procedures and programme of drills.

The inspector noted that each building was provided with emergency lighting, firefighting equipment and a fire detection and alarm system.

The fire detection and alarm system in each dwelling was provided with a panel inside the main entrance. Each system consisted of two zones. At the time of inspection, each panel was observed to have no faults and appeared to be in proper working order. There was a number of storage presses located in the staircase enclosures which were not provided with smoke detection.

The inspector noted the provision of emergency lighting throughout the centre in each house, including coverage of the internal escape routes and outside final exits. Records available to the inspector showed that the emergency lighting systems were being serviced. First aid fire fighting equipment was evident throughout and was noted as

having been serviced.

The primary concern identified by the inspector in relation to fire safety in the centre was the lack of fire doors in each building. Fire doors were not provided to protect the means of escape and to prevent the spread of fire and smoke throughout each building. As a result of this, residents are at serious risk should a fire related event occur. In one house the walls separating the stairs enclosure from the bedrooms and office had openable vents fitted in the wall. The other house was found to have glazed panels over some of the bedrooms doors with a gap between the glass and frame. The glazing was not fire resistant glazing.

In one house, there was a fire door located between the dining room and living room. The door was not fitted with a cold smoke seal to the head and jambs of the door and was fitted with a hook to hold the door open. In addition, the self-closing device was not capable of closing the door against the latch fitted to the door.

Final exits were noted to be locked and required a key to open them. The use of key locks were not found to have a risk assessment carried out. A key was provided in a break glass box adjacent to the door concerned. However, it was noted that different exits required different keys and that not all staff had appropriate keys on their person to open the doors. Similarly, each house had two external escape routes leading along the side paths of the house. Each route had a gate which was locked with padlocks which required different keys.

The inspector noted that all internal doors had key-locks. Staff confirmed that there was no risk of residents locking themselves into their rooms. Keys were kept in the office which was locked when not occupied.

The inspector noted that there were areas used for storage of combustible materials which were not separated from the escape routes with construction capable of containing fire and smoke.

The dryer in each house was found to have lint build up where the ventilation duct terminates externally, however from talking to staff the lint was removed regularly from the dryer internally. The inspector advised that the cleaning of the external ventilation grill should form part of their regular checks.

There was a fire procedure in place in the centre and was clearly displayed in each dwelling clearly and legibly in both text and drawing format. It is noted that the two dwellings forming the designated centre are in close proximity and would serve as a resource for both evacuation and supervision after an evacuation has taken place.

The inspector reviewed the fire safety register in each house. In each case the details of the premises was not entered into the register. While regular checks of the various systems with details of faults reported were entered into the register, improvement was required with regard to the records kept. For example, daily checks of the fire alarm panel were not logged in one house, and monthly checks of the first aid fire fighting equipment was not logged in the other.

Fire drill records were available indicating that fire drills were being carried out in the centre, although there were no records of night time drills. For one house the records were comprehensive, detailing each residents response to the drill and improvements were noted where difficulties had arisen. However, the record of drills for the other house was rudimentary in nature and indicated times for evacuation which were considered to be excessive. Improvement was required to ensure that residents could be evacuated from the centre in a timely manner in the event of a fire. Inspectors also noted that those residents who availed of the respite service were not in attendance during drills.

It was noted that for one house, the assembly point was located across the road, potentially presenting health and safety risks during drills. The inspector found that the suitability of the assembly point required review to ensure that residents would be in a safe location following evacuation from the house.

The inspector found that the needs of residents in the event of a fire were assessed by way of Personal Emergency Evacuation Plans (PEEPs). The content and layout of the PEEPs were found to be comprehensive and adequately detailed to inform staff of the residents needs in the event of a fire.

The inspector spoke to staff, and found them to be knowledgeable on the principles of fire safety and the evacuation requirements of the centre. Records demonstrated that escape routes, both internally and externally, were being checked twice daily. The inspector also saw documentation which showed that a record was maintained at all times of who was in each dwelling, detailing what staff and residents had vacated the house and at what time they returned.

The inspector reviewed records for fire safety and evacuation training for the centre. The records showed that a number of staff had not received training within the previous 12 months. The inspector discussed the issue with a staff member who confirmed that the training was up-to-date, however indicated that the records had not been sufficiently updated.

At the previous inspection it was found that the risk management policy required review. The policy has been reviewed since that inspection.

At this inspection, inspectors found that a review of the risk register and the management of risks in the centre indicated that the risk management system required improvement. A number of identifiable hazards required risk assessment. In one house, identifiable hazards included an open edge in a back garden, a kitchen window that did not have a restrictor at head-height, non-standard window restrictors on windows in the upstairs landing (one of which was broken) and a low banister with large gaps between panels in the same upstairs landing of one house. In the other house, risk assessments had not been completed for raised thresholds at external access doors. This was of particular relevance for residents who were wheelchair users and was also discussed in the context of accessibility under Outcome 6. In both house, external garden furniture was found to be in a poor state of repair with exposed sharp edges.

In addition, it was not clear from a review of risk assessments what the residual level of risk was following the implementation of control measures to manage a number of risks. In other risk assessments, it was not clear why the level of risk remained 'moderate' and what else was being done to reduce the level of risk further.

There was however evidence of learning from incidents, whereby a risk assessment had been completed for residents who attend the swimming pool and information required to support residents to swim safely was shared between the centre and the pool staff.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

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

Findings:

At the previous inspection, gaps in training as it related to positive behaviour support were identified. Training records indicated that some staff required refresher training and this will be addressed under Outcome 17: Workforce.

At this inspection, the inspector reviewed a sample of positive behaviour support plans, spoke with staff and observed interactions between staff and residents. Positive behaviour support plans had been developed where required with input from a clinical nurse specialist (CNS) in challenging behaviour. The CNS had completed reviews of such behaviour support plans at specific intervals. Reviews demonstrated that interventions were assessed and withdrawn where no longer 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):

No actions were required from the previous inspection.

Findings:

This outcome was included due to findings identified on inspection. Aspects of this outcome were identified as major non-compliances under other outcomes on the previous inspection where it was found that staffing levels and access to transport were not always adequate to support the effective delivery of service around activation and social participation appropriate to the needs of residents.

As previously mentioned under Outcome 5, a comprehensive assessment of residents' general welfare and personal development needs and wishes had not been completed. This was of particular relevance as seven residents in this centre had no access to a day service or other day programme outside of the centre.

The inspector spoke with staff, observed how residents spent their day and reviewed a sample of files for residents who did not have a day programme outside of the centre. An activity timetable was in place for each house for each weekday. Timetables included time outside of the centre each day, such as a walk, social outing of choice or a swim. Activity logs were maintained which indicated that residents accessed the community most, but not every day. Activities or interests offered inside the centre included art, baking, listening to music, beauty therapy or 'table top' activity (such as making jigsaws). In one house, a separate activity room was available with a computer, board games, television and tables and chairs. Where indicated, an individual activity programme had been developed with input from behaviour support services and records indicated that this programme was being followed.

However for the majority of residents without a day service, there was no review in residents' personal plans of whether the activity timetable in place met their individual assessed needs, wishes and preferences. In addition, action plans included in residents' personal plans did not outline how this gap in the provision of a day programme outside of the centre would be addressed for those residents who required access to such a programme/service.

In addition, there was no dedicated transport to this centre during normal working hours. Since the previous inspection, transport had been made available and shared between the two houses in this centre each evening during the week and on weekends. Staff told the inspector that this had made a significant difference to the options available to residents during those times.

During weekdays, staff explained that they had access to a regular and reliable public transport system and that other amenities and facilities were within walking distance. Taxis could be used on occasion if necessary. Staff with whom the inspector spoke said that while they could benefit from increased availability of dedicated transport, that they were able to manage using public transport and that appointments or outings had not been cancelled as a result of not having their own transport.

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

Findings:
At the previous inspection it was found that in some instances access to healthcare professionals such as a dietician, or recommended therapies such as hydrotherapy, were not always available. At this inspection, the inspector found that residents' healthcare needs had been assessed and healthcare management plans were in place and were being implemented by staff. Residents had access to medical care and required interventions. Allied health input had been sought where required, for example from the speech and language therapist, dietician and occupational therapist. Recommendations from allied health practitioners were being implemented in practice, for example in relation to modified diets and the monitoring of residents' weight.

However, the inspector found that where the clinical nurse specialist in challenging behaviour had recommended a referral to the psychiatrist in November 2015, this referral had not taken place at the time of inspection (seven months later). While a reason for this delay was offered by the staff nurse, the appropriateness of such a delay had not been discussed at a case conference or other relevant forum.

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):

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

Findings:

At the previous inspection, it was found that the annual report required development to fully meet the requirements of the regulations in relation to providing an effective overview of management systems on an annual basis. At this inspection, the representative of the provider confirmed that the format of the annual report had been reviewed since the previous inspection.

The inspector reviewed a bi-annual unannounced visit of the centre that had been completed in February 2016. The visit assessed 11 outcomes. The report of the visit reflected progress that had been made since the previous inspection, including in relation to consultation with families and the development of easy-to-read documentation for residents. The report also identified some areas that required further improvement, such as risk assessments and the development of long-term goals for residents to make them more specific. However, further improvement was required to the unannounced visits as a number of failings identified on the previous inspection and on-going issues were not included in the report or the action plan of the report. For example, the report did not consider the lack of day service for seven residents in the centre, that the review of the personal plan was not multi-disciplinary, that some parts of the premises were not fully accessible to wheelchair users, that there were outstanding fire improvement works in the centre, whether or not the lack of dedicated transport during the day had an adverse impact on residents' ability to participate in outings and activities of their choice or whether staffing levels were adequate to support residents' needs.

There was an audit schedule in place to monitor the quality and safety of care in the centre. Monthly audits included medicines management, cleaning, infection control, mealtimes, falls, fire safety and a training course audit. Three monthly audits included personal and intimate care, care plans, client forums, privacy and dignity and environmental aspects. An annual medicines management audit was also completed by the pharmacist in September 2015, which did not identify any medicines management gaps.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

At the previous inspection it was found that the lack of consistent access to an appropriate transport facility did not ensure the effective delivery of care and support to meet the needs of residents to achieve their individual personal plans. At this inspection and as discussed in detail under Outcome 10, the availability of transport had been increased since the previous inspection during the evenings and at weekends. Overall, a review of activity timetables, completed activity logs and discussions with staff and residents indicated that the lack of a dedicated transport service was at the time of inspection not preventing residents had access to the community in accordance with their individual needs, wishes and preferences. As mentioned under Outcome 14, this area will require on-going monitoring by the provider as part of the overall governance and management of the centre.

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):

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

Findings:

At the previous inspection, it was found that staffing levels were not always adequate to support the effective delivery of service around activation and social participation appropriate to the assessed needs of residents. As part of the provider's action plan following that inspection, the provider said that they would carry out a review of current staffing levels allocated to the centre, apply for volunteers to support activities in the centre and facilitate intellectual disability nursing and FETAC care assistant student/trainee placements, which would in turn provide increased supports for day time activities also.

With respect to the review, the representative of the provider confirmed that the review had been completed and that a business case was being prepared in relation to staffing requirements.

Over the course of the inspection, the inspector found that nursing students and care assistants on placement were involved, in a supervised way, in supporting residents who did not have a day service to pursue various activities and interests both within and outside of the centre. In addition, staff told the inspector that a relief staff member had commenced in the centre. Staff said that the combination of these increased supports meant that residents were being supported to pursue activities and interests of their choice.

However, the student/trainee placements were near-completion and a period of extended staff leave was planned. It was not clearly demonstrated how required staffing levels and supports, in accordance with the statement of purpose, would be maintained in the centre.

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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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 report¹

Centre name:	Cork City North 2
Centre ID:	OSV-0003696
Date of Inspection:	20 June 2016
Date of response:	15 July 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 02: Communication

Theme: Individualised Supports and Care

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

As detailed in the findings, improvements were required to ensure that individual communication supports were clearly outlined in each resident's personal plan.

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 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

PIC and Team Leaders will amend the current communication documentation to include Lámh signs used by residents. The new passport will be implemented in both locations.

Proposed Timescale: 31/08/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

A comprehensive assessment of residents' personal and social care needs and preferences was not in place to inform each resident's personal plan.

2. 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:

PIC and Team Leaders are scheduling meetings with residents, families and relevant members of multidisciplinary team to review personal care plans.

As part of this review process PIC and staff will focus on health, personal and social care needs of the residents. A review calendar for plans will be put in place.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

The review of the personal plan was not multidisciplinary as required by the regulations. Where members of the multidisciplinary team had attended reviews for some residents, this was not documented.

3. 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:

PIC and Team Leaders are scheduling PCP review meetings and will ensure that all multi-disciplinary input is clearly documented. Identified gaps in documentation have been corrected and amended.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

As detailed within the findings, it was not demonstrated how the effectiveness of the personal plan was assessed.

4. 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:

PIC and Team Leaders are scheduling meetings with residents, families and the relevant members of the multidisciplinary team to review residents' personal care plans. Based on the information acquired and discussions at the meeting, the PIC will plan a course of action to achieve any agreed outcomes. Person(s) responsible for implementing any agreed goal(s) will be noted and a date for a review meeting will be arranged.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

Where residents were wheelchair users, it was not demonstrated that an assessment by a suitably qualified person had been completed so as to ensure that the centre met that resident(s) needs in terms of accessibility.

5. 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:

A referral has been sent to Occupational Therapy Department to assess the suitability of the environment for wheelchair users identified in the report. Action plan will be developed on completion of this report and a copy of this plan will be forwarded to HIQA Inspector.

Proposed Timescale: 30/10/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

A number of window frames were old and damaged and required replacing. A completion date of 31 December 2016 had not yet passed.

6. Action Required:

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

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

A quote for works has been received and an application sent to the main funding body requesting funding. To date no sanction has been received to proceed with replacement. The provider is actively negotiating to receive funding however we are unable to commit to this major expenditure in our current funding allocation. This is a major priority for us in 2017.

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

As detailed within the findings, the centre was not accessible to those who lived there. In particular:

In one house, toilet/shower facilities and access and egress to and from the rear garden was not accessible to all and free movement between the dining and living area was not facilitated for all;

In the other house, the rear garden was not an accessible space for all.

7. 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:

PIC met with Facilities manager and Provider Nominee on 13/07/2016 to discuss action plan and agree schedule of works:

In the first house, work to be carried out is:

- Magnetic door locks will be fitted to three doors, linked to fire evacuation system to ensure access to communal areas in house for all residents. The fitting of magnetic door locks in the first house was dependent on internal funding. These works will be

completed by 31/08/2016. This will provide an appropriate mechanism between the kitchen and living room for residents.

- An assessment has been completed by the Occupational Therapy Department to assess the suitability of the toilet/shower environment for wheelchair users identified in the report. Quotes from builders in relation to replacement of the downstairs bathroom and other ancillary works are being sought. The date of the timeframe for completion of OT report and development of action plan has been brought forward to 23/09/2016.

In the second house, the current residents in the house are all ambulant, the step does not present as an issue. If the profile of residents changes or their needs change, the step will be reviewed.

Proposed Timescale: 23/09/2016

Theme: Effective Services

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

In one house, the shower chair seat required replacement.

8. Action Required:

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

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

A wall mounted shower chair has been ordered.

Proposed Timescale: 03/08/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Fire exits and gates along external escape routes, which were locked with key operated locks were not provided with appropriate safeguards to ensure they can be opened in the event of an evacuation.

9. Action Required:

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

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

PIC has requested for one set of locks for external doors, extra keys for break glass units and staff members, once funding is sanctioned it will take 4 weeks to complete works. The keys required for these doors are a special order as they are master keys. Internal funding was approved and the order was placed. The supplier gave a lead time of 3 weeks. We are now awaiting delivery and as soon as they are received they will be fitted. The fitting of the locks should be completed by 31/08/2016

Proposed Timescale: 31/08/2016

Theme: Effective Services

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

The means of escape in the event of a fire were not adequate in the following respects: The doors along escape routes and to rooms posing a risk of fire were not fitted with doors capable of containing a fire and preventing the spread of fire and smoke throughout each building in the designated centre.

The walls separating stairs enclosures from bedrooms/office were found to have openable vents and non fire rated glazing panels over some doors.

10. Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

"The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response".

Proposed Timescale:

Theme: Effective Services

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

As detailed in the report, each building was not constructed in a manner capable of containing a fire and preventing the spread of fire and smoke through the building.

There was a number of storage presses located in the staircase enclosures which were not enclosed in construction capable of containing a fire and some were not provided with smoke detection.

There was a fire door located between the dining room and living room in one house which was not fitted with cold smoke seals and was fitted with a hook to keep the door in the open position. In addition, the self closing device was not capable of closing the

door against the latch fitted to the door.

11. Action Required:

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

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

"The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response".

Proposed Timescale:

Theme: Effective Services

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

The suitability of the assembly point required further review to ensure that residents would be brought to a safe location following evacuation of the centre.

12. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

PIC met with Facilities Manager on the 13/07/2016 to review location of evacuation assembly point.

The current fire assembly point is to the front of the house and is within 10 metres of the centre, the location chosen gives a direct line of sight of the building for staff members and residents during an evacuation. There are two staff members on duty day and night; this gives a ratio of 1 staff to 3 residents which is sufficient to ensure their safety at the current evacuation point.

Proposed Timescale: 22/08/2016

Theme: Effective Services

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

Records for fire and evacuation training were either incomplete or out of date.

13. Action Required:

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

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

PIC has booked the two staff members requiring refresher fire training on the next available course on 29/07/2016.

PIC will review and amend site specific training record system to ensure training records are accurate in Cork City North 2.

PIC will continue to liaise with Human Resource Department to ensure all records are updated and accurate.

Proposed Timescale: 31/07/2016

Theme: Effective Services

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

The inspector did not find evidence among the fire drill records that night time drills had taken place as part of the fire drill program.

The records for evacuation drills in one house required more detail and indicated times for evacuation which were excessive.

The inspector noted that residents who availed of respite service were not in attendance during drills.

14. 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 site specific fire evacuation procedures will be amended in both locations in regards to the night time fire evacuation drills and respite residents.

The fire evacuation drills will be documented in full as per the regulation in unit identified in report. The PIC will complete an audit of the site specific protocols to ensure compliance and implement action plans where required.

Proposed Timescale: 31/08/2016

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:

It was not demonstrated that residents' general welfare and development was provided for in accordance with evidence-based practice, having regard to the nature and extent of residents' ability and assessed needs and his or her wishes.

A comprehensive assessment of residents' general welfare and development needs and wishes had not been completed.

There was no review in residents' personal plans of whether the activity timetable in place met resident's individual assessed needs, wishes and preferences.

Action plans included in residents' personal plans did not outline how this gap in the provision of a day programme outside of the centre would be addressed for those residents who required and wished to access such a programme or service.

15. 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:

PIC and Team Leaders will ensure all residents will have a comprehensive assessment of their educational, employment and training goals documented in the personal care plans. PIC will ensure progress in meeting these goals is documented in residents' personal care plans, including the current discussions with Managers of Day Services. All activity timetables will be reviewed regularly (every 3 months) and the review documented in clients personal plans.

Proposed Timescale: 30/09/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Where the clinical nurse specialist in challenging behaviour had recommended a referral to the psychiatrist in November 2015, this referral had not taken place at the time of inspection (seven months later).

16. 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:

Outstanding referral has been sent to Consultant Psychiatrist.

PIC will ensure all future referral recommendations will be promptly followed up and acted upon in a timely manner.

Proposed Timescale: 22/08/2016

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:

As detailed within the findings, further improvement was required to ensure that all aspects of safety and quality of care and support provided in the centre were adequately assessed from a governance perspective and a plan put in place to address any concerns regarding the standard of care and support.

17. 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 new format of the annual Safety and Quality of Care report will ensure all failings of standards will be included in the report and subsequent action plan. The provider nominee will schedule an annual review within three months, using the new format report. PIC will ensure a copy of the report and action plan will be available in each house.

Proposed Timescale: 31/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

As detailed in the findings, it was not clearly demonstrated how required staffing levels and supports, in accordance with the statement of purpose, would be maintained in the centre.

18. 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:

PIC meets regularly with Provider Nominee to review staffing allocations in Centre. A review of future staffing levels will be completed by Provider Nominee to ensure appropriate support levels are in place. In addition PIC will continue to liaise with Volunteer Coordinator and Clinical Placement Coordinator to ensure student/trainee placements will continue in Centre.

Proposed Timescale: 31/10/2016