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

### Centre ID:
OSV-0005395

### Centre county:
Cork

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

### Registered provider:
COPE Foundation

### Provider Nominee:
John Buttimer

### Lead inspector:
Geraldine Ryan

### Support inspector(s):
Carol Maricle; Mary Moore; Noelle Neville

### Type of inspection
Unannounced

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

### Number of vacancies on the date of inspection:
1
About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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: 23 June 2016 08:45  
To: 23 June 2016 17:30

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

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Summary of findings from this inspection
Background to inspection
A monitoring inspection took place on 5 November 2014. At that time, the centre consisted of eight houses with a maximum capacity for 41 residents. Following this inspection, due to serious non-compliances identified by inspectors, the centre was put on a compliance plan. The provider submitted an application to register the designated centre on 4 February 2015.

Subsequent inspections of the centre were carried out by the Authority on:
- 31 March 2015 (an unannounced inspection to follow up on actions generated by the inspection carried out on 5 November 2014). Due to the serious non-compliances identified by inspectors, an Improvement notice was issued by the Authority to the provider on 17 April 2015
- 3 June 2015 (an unannounced inspection to follow up on the submission by the provider, subsequent to the issuing by the Authority of an Improvement notice to the provider).

Due to the continued serious non-compliances identified on inspections, the Authority, on 30 June 2015, issued a Notice of Proposal to refuse and cancel the registration of this centre to the provider.
An unannounced inspection was undertaken on 1 September 2015 to follow up on actions generated by an unannounced inspection carried out on 3 June 2015. At the inspection carried out on 1 September 2015, overall, inspectors found that there were significant improvements from previous inspections, with an adequate level of compliance with Regulations. The quality of residents’ lives had been improved by the provision of dedicated activation staff in each house. Associated documentation was reviewed which indicated that individualised plans were being developed for each resident.

Staffing levels had been increased since the previous inspections. However, an unsolicited receipt of information had been received by the Authority, before the inspection carried out on 1 September 2015, in relation to low staffing levels. In addition, even though the management team had been augmented since the previous inspection, this had not been maintained on a daily basis. For example, the provider and the person in charge informed inspectors that the new clinical nurse managers (CNM), who had been assigned to augment the management team, were required also to fill in for nurse vacancies, in the houses. This resulted in an immediate action plan being issued to the provider in relation to the number and skill mix of staff on duty on a daily basis.

Following the inspection of 1 September 2015, a reconfiguration of the designated centre was undertaken, resulting in establishment of this centre as a standalone designated centre.

This inspection carried out on 23 June 2016 was an unannounced follow up inspection carried out to monitor compliance with regulations and standards. As part of the current inspection, inspectors reviewed the actions the provider had undertaken since the previous inspection.

How we gathered our evidence
As part of the inspection, inspectors met with 12 residents accommodated in each of the three units which comprised the designated centre. Some residents were able to tell inspectors that they liked the staff, enjoyed living at the centre and invited inspectors to see their bedrooms. Where residents were unable to tell the inspectors about their life in the centre or of the quality of the service provided, inspectors spent time with residents and observed staff interacting with residents in a respectful and dignified manner. Inspectors observed residents being encouraged to make choices on the activities they were participating in. Residents appeared relaxed with staff throughout the inspectors’ presence in the centre.

The centre’s person in charge, while on annual leave, came to the centre on the day of inspection. The inspectors also met with the provider’s representative, the person participating in management (PPIM) who was acting person in charge, a CNM, a clinical nurse specialist (CNS) in positive behaviours, nursing and care staff at the centre.
During the inspection, inspectors observed care practices, staff/resident engagement and interaction and reviewed centre, resident and staff – related documentation such as care plans, medical records, the complaints record, the risk register, minutes of meetings and staff training records.

Description of service
The provider’s statement of purpose, as required by regulation, described the service provided. Inspectors found that the service was being provided as it was described in the centre’s statement of purpose. The centre was located on a campus with access to local amenities. Transport, provided by the centre, was available to the residents. The centre was purpose built and comprised three, six-bedroom self contained houses, two of which were connected by a keypad accessible corridor. Each self contained house had its own kitchen, dining room, sitting room, music room, bathrooms, laundry room, cleaning room, linen room, toilets (residents and staff), staff changing facilities and an office. Currently, 17 residents resided at the centre. The centre accommodated both male and female resident with all levels of intellectual disability and/or autism from the age of 18 years.

Overall judgement of findings
Overall, inspectors found that senior management had undertaken significant measures to address required actions from the previous inspection. While further measures were required in areas described in the body of this report, the safe care and quality of the residents’ lives were enhanced and this was evidenced by the response from residents, inspectors’ observations of resident/staff engagement and the quality of the information available in the residents’ personal care plans.

The centre had a warm homely atmosphere and residents appeared comfortable and relaxed. Housekeeping, furnishings and décor were of a high standard.

Inspectors after reviewing evidence during the inspection were satisfied that the provider had put systems in place to ensure that the regulations were being met. The person in charge, the PPIM, the CNM, nursing and care staff demonstrated their knowledge of the residents and their social and healthcare requirements. Good practice was identified in areas such as:
• communication tools used (Outcome 2)
• convening of the audit safety and risk committee; resident participation in fire drills; standard of housekeeping (Outcome 7)
• residents’ access to health care interventions were established to ensure needs were fully met appropriately (Outcome 11)
• the person in charge provided good leadership, and was engaged in operational management and administration of the centre on a regular and consistent basis (Outcome 14)

However, improvements were required in the following areas:
• complaints management (Outcome 1)
• residents’ personal care plan were not available in an accessible format (Outcome 5)
• residents' goal setting (Outcome 5)
• a resident’s risk assessment and care plan in relation to falls prevention management required review to include recommendations from allied professionals
(Outcome 7)
• a resident’s risk assessment in relation to potential choke risk was not dated
(Outcome 7)
• documented terminology used by staff in relation to when a resident could /or not receive a token required review to ensure the resident’s right to decide for example, if they chose or not to go out to a day service, was not impinged (Outcome 8)
• a small number of staff had not attended mandatory/refresher training or training in the use of a manual sign system used as a communication tool (LAMH) (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 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:
The action generated in the inspection 1 September 2015 was completed in a satisfactory manner. An inspector noted that a collective complaints log, commenced 28 September 2015, was kept centrally. Each unit within the designated centre now had a separate complaints log. Perusal of same by an inspector evidenced that each complaint was recorded and actioned and there was evidence that the complainant was satisfied with the outcome. However, an inspector noted documented in a resident's personal plan, a concern raised by a resident's relative and it was not clear if this concern was addressed. While staff interviewed were able to demonstrate that the concern was addressed, this matter was not included in the complaint log.

Inspectors' observed staff interacting with residents in a positive and respectful manner. Staff were very knowledgeable with regard to residents' general likes/dislikes; for example; activities, meals, how residents liked to decorate their bedrooms and preferred items of clothing residents chose to wear. Residents were supported to keep their own belongings. On the day of inspection, residents' personal care practices respected the residents' privacy and dignity.

Residents had access to a variety of activities and residents' activity logs evidenced this. On the day of inspection residents went swimming, to the day centre, listened to music and attended a karaoke session in the afternoon. Since the most recent inspection the staff cohort had been enhanced by the addition of two activation coordinators; one assigned to one house and one assigned to the two other houses in the centre. Staff confirmed how this had enhanced the day to day life of the residents.
Judgment:
Substantially 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:
Staff were aware of the different communication requirements of the residents. Inspectors evidenced comprehensive and detailed communication tools which had been developed to guide and inform staff as to the needs of each resident. Management stated that it was planned to role this particular tool throughout the centre for all residents. The plans were cognisant of non-verbal techniques used by residents to communicate. Residents had individual communication dictionaries complete with documented strategies enabling staff to communicate with residents; for example residents’ communication tools had photographs of the sign unique to that resident, information about what the sign meant and guidance for staff on the interpretation of the sign. This was observed in practice by inspectors.

Residents had access to TV, DVDs and radio. Documented allied professional input from speech and language therapists augmented residents' communication processes.

Residents engaged with inspectors and invited inspectors to view their home.

Key information, for example, in relation to fire, complaints, was available in an accessible format.

Judgment:
Compliant

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

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

Findings:
Inspectors, upon review of a sample of plans in each of the three units, evidenced that a
detailed synopsis of residents' needs and routines was evident and that the plans were
person centred. There was evidence that plans were updated if there was a change in a
resident's need. All residents' plans were due their annual review; July and August 2016;
and senior management stated that letters had been sent to residents' relatives in May
2016. This information was evident in residents' personal plans. A copy of the invitation
letter was not evident in the residents' plans. The person in charge gave an undertaking
to include a copy of the letter in each resident's plan.

All residents had access to appropriate services; for example; psychiatry, general
practitioner (GP), clinical nurse specialists (CNS) in positive behaviour support, speech
and language therapy, occupational therapy, dietetics, physiotherapy, chiropody,
podiatry, psychology and dental services. While there was ample evidence that residents
had been reviewed by allied professionals and on an ongoing and regular basis however,
it was not clear if the review of the residents' support plans was part of a formal
multidisciplinary team review. Senior management acknowledged this and stated that
the priority post the most recent inspection of the 1 September 2015 was that all
residents were reviewed by the allied and specialist services. This had been completed
and there was documentary evidence of this. Senior management stated that a formal
multidisciplinary review of the residents was now being commenced.

Residents' personal plans were available in an accessible format. However, while there
was evidence that residents and relatives were involved in planning and reviews, senior
management confirmed that residents and relatives were not provided with copies of
the plan and gave an undertaking to address this.

Considerable progress had been made with regard to residents setting the goals they
wished to achieve. From a review of residents' plans from the three units in the
designated centre, there was evidence that this process was more advanced in some
residents' plans; for example, most residents' plans reviewed had measurable and
specific goals for 2016 and a review of stated goals had been undertaken.

However, two residents' personal plans identified:
- goals were generic and not specific and it was unclear as to how a goal was linked to a
resident's overall general development; for example; noted as goals were; 'outings' and
'activation' and 'shopping'
- it was not clear who devised and agreed the goals
- it was not clear if a goal had been achieved/or not.
**Judgment:**
Substantially Compliant

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<thead>
<tr>
<th><strong>Outcome 07: Health and Safety and Risk Management</strong></th>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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<th><strong>Outstanding requirement(s) from previous inspection(s):</strong></th>
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<td>The centre had a site specific risk register, capturing associated risks for the designated centre. This was held centrally in the administration office onsite. At the most recent inspection it was stated by a CNM that a copy of the risk register would be printed off for each house. This had not yet occurred. The person in charge, the person participating in management (PPIM) and the CNM gave an undertaking to locate a copy in each house.</td>
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Arising from the most recent inspection, the person in charge, the PPIM and the CNM had implemented an audit, safety and risk committee which convened on a monthly basis. The terms of reference for the committee was to develop and implement an overall governance strategy based on safety, risk, quality and development. Membership comprised staff of all grades and departments. Minutes reviewed evidenced that, for example, incidents/accidents/a restrictive practice and residents' individual risk assessments were discussed. There was evidence that resulting action plans were put in place, complete with a staff member identified as responsible for completing the action and by a determined date.

An inspector reviewed aspects of fire safety and the following was noted:
- all fire equipment was serviced
- daily checks of escape routes were performed twice daily by a designated person
- fire drills were completed. Three drills had recently been carried out with evacuation times between two and three minutes. There was evidence that residents participated in fire drills. However, the times the day/night drills were carried out were not documented
- while residents had a personal evacuation plan capturing their mobility requirement and cognitive understanding, individual fire evacuations plans contained in a fire folder were undated.

Medications stored in the medication fridge were named and dated. However, some gaps were noted the recording of the daily temperature of the medication fridge.

Each resident had a suite of risk assessments pertinent to their needs. One resident had a falls risk assessment carried out in June 2015. While staff ably described the resident’s needs and the controls in place, for example, physiotherapy, chiropody and orthopaedic review, this information was not contained in the resident’s falls risk assessment. A risk
assessment for a resident at risk of choking was not dated. However, staff demonstrated their knowledge of what they would do in the event of the resident incurring an episode of choking and there was evidence that a resident’s care plan was updated post an incident and that the resident had been reviewed by a speech and language therapist.

Staff voiced their knowledge on the matters arising from and learnings gleaned from the monthly audit, safety and risk committee meetings and also stated how this helped them feel included in how the residents were cared for.

The housekeeping and cleanliness in each house was of a high standard. Staff were observed using protective personal equipment while carry out housekeeping duties. Doors to sluice and housekeeping rooms were safely secured.

Judgment:
Substantially Compliant

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):
No actions were required from the previous inspection.

Findings:
Measures to protect residents from abuse were in place. 32 staff had received training in safeguarding vulnerable adults and training for four staff was outstanding. Staff training is discussed in more detail under outcome 17: Workforce.

Staff spoken to were knowledgeable in regard to safeguarding vulnerable residents and were observed interacting with residents in a cordial and respectful manner. Residents were observed mobilising at their own pace or accompanied by staff and were observed interacting with, chatting and responding to staff.

Notifications submitted to the Authority were timely and informative with regard to protections in place to ensure the safety of residents.

Residents had personal care plans in relation to intimate care and efforts to preserve the privacy and dignity of residents attending to their personal care requirements were evident.
All residents had a multi-element behaviour (MEB) plan. This was underpinned by the centre's adult protection threshold guide which clearly outlined the types and levels of behaviours. This guide was reviewed in February 2016 and the PPIM stated if a resident exhibited more than two incidents of a particular behaviour per month, the threshold guide is referred to, in discussion with the provider representative to determine whether an incident constitutes challenging behaviour or is a notifiable event, and if further escalation is necessary. The multi-behavioural support comprised the person in charge, PPIM, staff and the CNS in positive behavioural support. A psychiatrist visited the centre weekly and was on site on the day of inspection.

Inspectors met with the CNS who specialised in positive behaviour support. The CNS operated on a referral basis and was involved in implementing the MEBS plan for residents and the training for staff on MEBS. The CNS stated that while all residents' MEBS plans were reassessed in 2015, no formal review to ascertain the effectiveness had been carried out as yet and this was to be planned. The CNS stated that staff were actively engaged in the MEBS plans and informal feedback from staff reflected the success of the implementation of the MEBS. Staff demonstrated an enhanced understanding of why a resident may exhibit a behaviour, and knowledge on how to manage an incident. A review of the residents' MEBS plans reflected clear guidance for staff on how to support a resident who may exhibit a behaviour that may challenge. While the CNS maintained records of referrals and notes post a referral, these records were kept in the CNS office in the administration office. The CNS gave an undertaking to ensure that advices of the CNSs were included in residents' on site files, accessible to the staff and residents and be utilised as part of the multidisciplinary review. There was evidence of the CNS review and advices in residents' care plans.

With regard to one resident's documentation, the senior management team was asked by inspectors to review the terminology documented by staff when describing an incidence of a resident exhibiting a behaviour. A system of tokens was used in relation to one resident. This system entailed that a resident could accumulate tokens as a result of exhibiting positive behaviours. The terminology used by a staff member in relation to when a resident could or could not receive a token required review to ensure the resident's right to decide; for example; if they choose or not to go out to a day service, was not impinged. The person in charge concurred with this observation.

The inspector also evidence documented terminology used by staff in another resident's file and the person in charge concurred that wording used by staff had no context in relation to what he/she was describing as a standalone matter. There was no evidence that the staff member had followed up on what he/she documented. The person in charge gave an undertaking to follow up and carry out an assessment of staffs' written communication skills. This is captured under outcome 17: Workforce.

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

**Theme:**  
Health and Development

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

**Findings:**  
The action indentified in the most recent inspection referring to residents' medical treatment (blood tests), had been addressed by the person in charge. Each resident had a dated record of when the required blood profile tests were taken; accompanied by the test results; and when the next tests were due.

There was evidence that residents' health care needs were met through timely access to health care services and appropriate treatment and therapies. Inspectors found that residents were supported on an individual basis to achieve and enjoy best possible health.

A sample of residents' health care plans from each of the three units were reviewed and it was found that residents had regular access to the GP, a psychiatrist who visited weekly, CNS in positive behavioural support, speech and language therapy, dietetics, occupational therapy, psychology, physiotherapy, dental services, chiropody and external specialist medical/surgical services.

There was evidence of a formal referral process to allied services and of the advices/recommendations arising from said reviews documented in the residents' care plans. From the sample of health plans reviewed it was evident that health promotion of each resident featured in the plans.

While residents' weights and basic observations (temperature, pulse, blood pressure) were routinely monitored, one resident's chart contained some gaps. On discussion with staff it emerged that while the resident chose not to have the observations/weight taken, this information was not documented. It is fair to state that all other residents' records reviewed did contain information if a resident refused to have his/her observations taken. While some documentary gaps were noted, there was evidence that the care and support was implemented in practice.

**Judgment:**  
Compliant
Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
Inspectors reviewed medication management practices in the centre and found that residents were safeguarded by the provision of safe medication management.

Medications stored in the medication fridge were named and dated. However, some gaps were noted the recording of the daily temperature of the medication fridge. This was actioned under outcome 7: Health and Safety and Risk Management.

An audit of medication management was carried out by the external pharmacy supplier in June 2015 and March 2016. No significant actions arose from the most recent audit. Transcription of medications was not used within the centre and any required prescription changes were documented by the GP and faxed to the external pharmacy supplier.

No medications were administered to residents in a crushed manner and no resident was currently prescribed a controlled medication. While no resident currently self administered medication, an assessment to ascertain if a resident could self medicate/or not had not been undertaken.

If and when there was an error in medication administration, this was discussed at the monthly audit, safety and risk meeting and learning communicated to staff. There was no evidence that errors were a regular or significant issue. The medication management audit carried out by the external supplier supported this.

The staff nurse comprehensively described a clear protocol for the administration of medication as required (PRN) and voiced how other alternatives were explored. PRN medication was only administered following consultation with the CNM on duty. When a protocol was implemented for a resident, there was evidence that it was on foot of consultation with the psychiatrist, the GP and the CNM.

Medications were stored in a safe manner and as per best practice guidelines.

Judgment:
Substantially Compliant
**Outcome 14: Governance and Management**

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Leadership, Governance and Management

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

**Findings:**
It was evident that the management systems in place ensured that the service provided to residents was safe, appropriate to the residents' needs and effectively monitored. Clear lines of responsibility and accountability at individual, team and service level were evident and all persons working in the centre were aware of their responsibilities and who they were accountable to.

The person in charge was in place since October 2015 and robust systems were in place in the event the person in charge was absent. The person in charge was on annual leave but came to the centre during the inspection. It was evident that the centre was managed by a suitably qualified, skilled and experienced person with the authority, accountability and responsibility for the provision of the service. A culture of quality and safety was evident; a monthly safety, audit and risk committee meeting augmented this.

A staff recruitment initiative was ongoing. Inspectors met with staff recruited within the last 12 months. Staff stated that they 'felt part of the team', that their opinions were valued and voiced they felt supported in their respective roles. Management and staff stated how the employment of two designated activation staff for the centre enhanced the lives of the residents accommodated there.

Residents had ready access to transport. One staff member informed inspectors that he/she was in the process of attaining a driving licence to allow driving of the centre's vehicle/s.

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

Findings:
On the day of inspection there were enough staff with the right skill, qualification and experience to meet the assessed needs of residents at all times. Nursing care provided was appropriate to the residents' assessed needs. Since the most recent inspection, five additional whole-time equivalent posts had been approved. However, the person in charge stated that the organisation was experiencing some difficulties in the recruitment and filling these posts.

There was a planned and actual staff rota and evidence that annual leave was managed in a coordinated manner to ensure continuity of safe quality care of the residents. Inspectors noted that residents received assistance, interventions and care in a respectful, timely and safe manner.

A review of staff training records indicated that of the 36 staff employed at the centre:
- 27 had completed training in the management of actual or potential aggression (MAPA); training was scheduled for two new employees; two staff were on long term leave; five staff were due refresher training
- 31 had completed training in safe manual handling practices; five staff were due refresher training
- 34 had completed fire safety training; one staff due refresher training and one staff was on long term leave
- 32 staff had completed training on the safeguarding the vulnerable adult; training for four staff was outstanding. The person in charge was aware of this and had a plan in place to address this.
Two staff had attended training on diabetes management.
The CNS in positive behaviour support and the person in charge delivered on site training to staff on MAPA and safe manual handling practices.

There was evidence that staff were assigned to units within the centre and this provided continuity for residents. Staff reported their preference to be assigned to a unit as it afforded the residents and staff to get to know one another. Staff rotated from day to night duty.

The person in charge and PPIM outlined plans to introduce team leaders to the centre. Training for team leaders was planned for 27 June 2016. A programme for the day was
made available to inspectors.

The person in charge stated that staff skill set was monitored on an ongoing basis. This was confirmed by the PPIM and the CNM who were regularly involved in these reviews. This matter was also discussed at the monthly meeting.

Inspectors evidenced terminology used by staff in residents' files and the person in charge concurred that wording used by staff had no context in relation to what he/she was describing as a standalone matter. There was no evidence that the staff member had followed up on what he/she documented. The person in charge gave an undertaking to follow up and stated that he would review staffs' written communication skills.

While one resident used Lámh; a manual sign system used as a communication tool; staff had not yet received training in this manual sign system. This matter had been highlighted in previous inspections.

**Judgment:**
Substantially Compliant

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

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<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by COPE Foundation</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005395</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>23 June 2016</td>
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<tr>
<td>Date of response:</td>
<td>04 August 2016</td>
</tr>
</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not ensuring that a record of all complaints was recorded.

1. Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:

1. Local complaints logs amended to include all relevant information, including complainant satisfaction - 28/06/2016.
2. Protocols regarding use of complaints logs reissued to staff, and discussed at all handovers.
3. Easy read complaints policy to be outlined to all residents by staff as necessary and at residents forum meetings.

Proposed Timescale: 30/08/2016

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:

Residents' personal plans were not made available in an accessible format to the residents and, where appropriate, their representatives.

2. Action Required:

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

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

1. Information provided for all residents, placed in their bedrooms, with information on how to access their personal plans and to ask staff for assistance if required – 28/06/2016.
2. Letters to be sent to residents representatives informing them that they can access resident’s personal plans at any time onsite in designated centre- 12/08/2016.

Proposed Timescale: 12/08/2016

Theme: Effective Services

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

Two residents' personal plans identified:
- goals were generic and not specific and it was unclear as to how a goal was linked to a resident's overall general development; for example; noted as goals were; 'outings' and 'activation' and 'shopping'
- it was not clear who devised and agreed the goals
- it was not clear if a goal had been achieved/or not.
3. **Action Required:**
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

**Please state the actions you have taken or are planning to take:**
1. Review of all residents personal plans to include information on how specific goals are identified, who was involved in decision, as well as follow ups to be completed by relevant staff such as keyworkers.
2. Full annual review of personal plans to include input from members of multidisciplinary team specific to each resident’s needs. All reviews to have taken place by 30th September 2016.

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

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**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:**
Residents' individual risk assessments were not dated and did not contain all relevant information.
- One resident had a falls risk assessment carried out in June 2015. While staff ably described the resident's needs and controls in place, for example, physiotherapy, chiropody and orthopaedic review, this information was not contained in the resident's falls risk assessment.
- A risk assessment for a resident at risk of choking was not dated.

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

**Please state the actions you have taken or are planning to take:**
1. All relevant risk assessments to be updated at least annually or as needed, to include all residents needs and controls, including signatures and dates.
2. Full risk register although available in office was made available to each house in designated centre, replacing summary version – 28/06/2016.
3. Individual risk assessments specified above were reviewed and updated.

**Proposed Timescale:** 04/08/2016
**Theme: Effective Services**

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some gaps were noted the recording of the daily temperature of the medication fridge.

**5. 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:**
1. Full risk register although available in main office was made available to each house in designated centre, replacing summary version – 28/06/2016.
2. Recording of daily temperature of medication fridge was raised and discussed at handover 24/06/2016.

**Proposed Timescale: 28/06/2016**

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**Theme: Safe Services**

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The terminology used by a staff member in relation to when a resident could or could not receive a token required review to ensure the resident's right to decide, for example, if they choose or not to go out to a day service, was not impinged.

**6. 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:**
1. Person in Charge reviewed specific behavioural support plan with staff outlining correct terminology to be used as per plan.
2. All behavioural plans are to be reviewed by Person in Charge with member of PBS Team by 31/08/2016.
3. An audit of staff written communication skills is to be carried out by 31/08/2016.

**Proposed Timescale: 31/08/2016**
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:
While no resident currently self administered medication, an assessment to ascertain if a resident could self medicate/or not not had not been undertaken.

7. 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:
1. All residents will have self-administration of medication assessment completed using organisation policy assessments.

Proposed Timescale: 14/08/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A small number of staff had not received mandatory training including refresher training.

Staff had not received training in a manual sign system as a means of communication (LAMH).

8. 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:
1. All staff are to be provided with appropriate refresher training, as well as new staff being provided with mandatory training on an ongoing basis.
2. Person in charge met with Clinical Nurse Specialist from communication team to discuss possible site specific LAMH training for staff relevant to needs of residents, staff to compile resident specific list of signs used by residents prior to training. Staff training arranged for the following dates:
   - Tuesday 13th September
   - Wednesday 14th September
   - Tuesday 20th September
   - Wednesday 21st September.
Organisation is also providing generic LAMH training in November, with 2 places available to designated centre. Staff attending these to assume responsibility for LAMH awareness in designated centre.

**Proposed Timescale:** 23/11/2016