<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Cork City South 2</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003295</td>
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<td>Registered provider:</td>
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<tr>
<td>Provider Nominee:</td>
<td>Bernadette O'Sullivan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Kieran Murphy</td>
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<tr>
<td>Support inspector(s):</td>
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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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From: 14 November 2016 08:00  
To: 14 November 2016 17:00  
From: 15 November 2016 08:00  
To: 15 November 2016 16:00

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 05: Social Care Needs</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 10: General Welfare and Development</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 12: Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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**Summary of findings from this inspection**

Background to the inspection:
This was the second inspection of this centre. The centre was managed by COPE Foundation who provided a range of day, residential and respite services in Cork.

It is a requirement of the regulations that all serious adverse incidents, including allegations of abuse are reported to the Health Information and Quality Authority (HIQA). A significant safeguarding incident had been submitted to the Chief Inspector in November 2016. This inspection was scheduled following receipt of the allegation. It was found on inspection that there was evidence that the issues raised were being investigated by the COPE Foundation in accordance with centre policy on protection of residents. The COPE Foundation undertook to inform HIQA of the outcome of their investigation of this issue. Due to the nature of the information submitted to HIQA, the inspection focused on the area of food and nutrition and mealtimes.

Description of the service:
The centre provided a home to 27 residents and was based in a congregated setting.
on a campus on the south side of Cork city. In addition to the centre, the campus also had sports fields and large day service facilities on site. All of the residents had high support needs with most residents needing assistance with all activities of daily living including eating and personal care. Many residents also had complex healthcare needs including epilepsy. The person in charge outlined that most of the residents had lived in residential care all their lives.

The centre consisted of two large interconnected bungalows. Bungalow one provided a home to 13 full-time residents with one bedroom allocated for respite care to people with a disability living at home; bungalow two provided a home to 11 full-time residents with two beds available for respite care.

A donation had been made to the centre from a local computer company which had been used to build a sensory garden for residents. The sensory garden included footpaths, flower beds, a water feature and was set amongst trees. Staff said that residents like to use this area, particularly in the summer months.

How we gathered our evidence:
As part of the inspection, the inspectors met with approximately 20 residents. One family was also available to meet and said to the inspector that their loved one was very well looked after and that they could visit at any time.

Inspectors met with staff during the inspection and observed their interactions with the residents. Staff had good knowledge of each resident's individual needs and were seen to support residents in a respectful and dignified manner. Inspectors also observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures.

Overall judgment of our findings:
There was some evidence of good practice. For example, this centre had recently participated in a European-wide survey on healthcare-associated infections (HCAI) and antimicrobial use in long-term care facilities. In addition, residents in the centre received a community epilepsy outreach service, coordinated through the neurology and epilepsy department in Cork University Hospital. The epilepsy outreach service was established in 2014 to provide high-quality specialist epilepsy care to people with intellectual disabilities living in residential care.

Of the 10 outcomes inspected, one was at the level of major non-compliance:
Outcome 1: Rights, dignity and consultation
Residents’ right to privacy and dignity was not respected by:
• the use of closed circuit television (CCTV) without adequate measures in place to safeguard the resident
• no evidence of any consultation with the resident about sharing the room
• one of the bedrooms did not have any curtains or window blinds
• paint peeling off the wall of one shared bedroom.

Seven of the outcomes were at the level of moderate non-compliance including:
Outcome 5: Social Care Needs
Improvement was required to ensure each resident’s individualised personal plan
reflected their needs, interests and capacities.

Outcome 8: Safeguarding and Safety
Restrictive procedures were not in line with national policy, evidence based practice or the organisation’s own policy.

Outcome 10: General Welfare and Development
During the inspection residents were observed spending long periods of time not engaged in any meaningful activities throughout their day.

Outcome 11: Healthcare
Guidelines and care plans to support residents at mealtimes were not being followed. Due to the level of support from staff required and the length of time residents required to eat their meals, the timing of meals required review to provide assurance that residents had access to meals, refreshments and snacks at all reasonable times.

Outcome 14: Governance
The inspector found that the person in charge had the necessary skills, knowledge and experience to discharge her duties. However, the person in charge was responsible for this centre and another designated centre managed by COPE Foundation in Cork city. Due to the size and layout of this particular centre and the complexity of the healthcare needs of some residents, these arrangements could ensure the effective governance, operational management and administration of both designated centres.

Outcome 17: Staffing
The number of staff required review to ensure that the assessed needs of residents were being met.

Outcome 18: Records
The system of records management did not adequately ensure that relevant healthcare information was available to plan care for residents.

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.
Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A single aspect of this outcome relating to residents’ rights and dignity was reviewed on this inspection. Improvement was required to ensure that residents’ rights and dignity were being respected.

The centre consisted of two large interconnected bungalows. Bungalow one provided a home to 13 full-time residents with one bedroom allocated for respite care to people with a disability living at home; bungalow two provided a home to 11 full-time residents with two beds available for respite care.

One of the bedrooms had a small hallway from the doorway which led to the bedroom space itself. There was another door here that was locked via a bolt when the bedroom was in use. This part of the room had closed circuit television (CCTV) which was turned on when the bedroom was in use. The person in charge had outlined that the use of CCTV “allowed staff to observe from the office at all times”. However, staff only observed from the office between 17:00hrs and 22:00hrs. This meant that the implementation of this protocol could not currently guarantee the safety of any resident using this bedroom as staff were not observing “at all times”.

In relation to residents’ privacy, during the inspection it was observed that one resident’s bedroom had a second bed in the room that was used by people accessing the service on respite breaks. There was no evidence of any consultation with the resident about sharing the room. In documentation relating to this resident their “rights plan” does not mention sharing their room with different people on a rotational basis. In addition, the resident’s “material well-being plan” it was identified as a goal “to make
(the bedroom) more homely for (the resident)”. On the day of inspection paint was observed to be peeling from the wall in the bedroom. Staff said that this was due to wheelchairs and hoists hitting against the wall.

There was no evidence of consultation and participation by residents in the organisation of the centre. The person in charge said that residents’ meetings do not take place but that two staff members were dedicated “advocacy champions” who advocated on behalf of residents at staff meetings. There was also a “family forum” where families were consulted about issues relevant to the centre and the care being provided. The most recent “family forum” had taken place on 12 September 2016.

The inspector observed that most bedrooms were tastefully decorated with residents’ own items of furniture and lighting. There was an up-to-date property list in each resident’s personal outcomes folder. The provider had completed an annual review on 7 September 2016 of the safety and quality of care and support provided in the centre. In relation to storage this review said that “there is no locked press to secure personal items for privacy”.

**Judgment:**
Non Compliant - Major

**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):**
No actions were required from the previous inspection.

**Findings:**
Improvement was required to ensure each resident’s individualised personal plan reflected their needs, interests and capacities.

There were three sets of resident records: the person centred planning folder that contained the care plans and person centred planning reviews; a separate file for medical and healthcare records that included records of reviews by medical doctors, consultant letters and blood test results; the “all about me” folder that contained easy read support plans
There were separate assessments of residents’ healthcare needs and social care needs in the personal planning process. In relation to social care needs, the care plans included issues such as:
- emotional well being
- personal development
- interpersonal relationships
- self determination
- material well being
- social inclusion
- physical well being and
- rights

There was a lot of repetition of issues in this care plan format with similar items being discussed under related headings like personal development and social inclusion. In addition, the relevant heading did not always contain the relevant information. For example, under the “rights plan” issues relating to restrictions on residents were not always included. There was no obvious link between these social care plans and the person centred planning review process. For example, one resident had a “skills development plan” that had been reviewed in January 2016. The plan outlined that the resident was to be motivated “to continue practising the skills they have”. However, this plan had been unchanged since 2012.

In relation to the required yearly review of residents’ personal plans, in many of the care plans seen by the inspector the resident was not always present for the annual review. In addition, the inspector found that the review of the personal plan and in particular the assessment of the resident’s health, personal and social care needs was not multi-disciplinary. This had also been identified by the service itself as part of the annual review of the safety and quality of care and support in January 2016; there it was said in relation to social care needs that “there was some evidence of multidisciplinary review; a required action to be carried is for immediate multidisciplinary review for all residents”. Plans did not adequately identify individual needs, choices and aspirations. For example, some of the personal goals and outcomes seen by the inspector included “monthly meaningful activities” and “monitoring health”.

In relation to healthcare needs each resident had a malnutrition universal screening tool (MUST) assessment undertaken to establish the nutritional risk for the resident. However, these assessments were not being undertaken as indicated on the MUST form itself. For example, if a score was recorded of “2” then the assessment was to be completed monthly. One resident had such a score but the assessment had not been repeated monthly.

Where required residents had pressure ulcer prevention care plans. Some residents had pressure ulcer assessment forms completed. However, there was no evidence that this assessment tool had been validated or adapted for people with the specific support needs of residents in this centre. For example, a lower score is recorded if the person is in the age range of 14-49 which may influence the outcome score of the total assessment.
Judgment:  
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management  
The health and safety of residents, visitors and staff is promoted and protected.

Theme:  
Effective Services

Outstanding requirement(s) from previous inspection(s):  
No actions were required from the previous inspection.

Findings:  
A single issue of this outcome relating to infection control was reviewed during this inspection, with good practice being noted.

This centre had recently participated in a European-wide survey on healthcare-associated infections (HCAI) and antimicrobial use in long-term care facilities.

One of the residents had a care management plan in place for infectious diseases. Staff spoken with were aware of the care plan and standard universal precautions were in place.

Judgment:  
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:  
Restrictive procedures were not in line with national policy, evidence based practice or the organisation’s own policy. Improvement was also required to support residents to
manage their behaviour.

It is a requirement of the regulations that all serious adverse incidents, including allegations of abuse are reported to HIQA. A significant safeguarding incident had been submitted to the Chief Inspector in November 2016. This inspection was scheduled on receipt of the allegation. It was found on inspection that there was evidence that the issues raised were being investigated in accordance with centre policy on prevention of abuse of residents. The COPE Foundation undertook to inform HIQA of the outcome of their investigation of this issue. Records were available to show that all staff had been trained in the safeguarding of vulnerable adults. The person in charge also confirmed that all staff had received this training.

The service provider was obliged to notify HIQA on a quarterly basis of any occasion on which restraint was used (such as physical, environmental or chemical). HIQA was notified in September 2016 that 21 residents had bedrails in place as a restraint while they were in bed and 17 residents had belts in place as a restraint “when in a chair”.

The COPE Foundation restrictive interventions review committee provided oversight of all restrictions throughout COPE Foundation service including this centre. In relation to one request for the use of bed rails the committee had advised in April 2015 that “the multidisciplinary team (MDT) needs to approve use in writing”. There was no documentation on file to verify that the MDT had approved the use of the bedrail. In addition, the restrictive practice committee had again written in June 2016 advising that a “fresh request” be made for the use of the bed rails in this case. Again, there was no documentation on file to verify if this “fresh request” had been made.

There was also a COPE Foundation policy on the use of restrictions that stated that prior to the use of any restriction a detailed risk assessment was required. The inspector observed the use of a monitor over one resident’s bed that alerted staff if the resident was in distress. However, a risk assessment to indicate the need for the monitor was not available in relation to this environmental restriction. There was no documentation available in relation to the approval of this restriction.

In the sample of healthcare files seen by the inspector one resident had a care plan entitled “behaviour support plan”. This care plan had not been updated since 2014. It referenced a “positive plan – see attached”. However, this was not in the documentation made available to the inspector. The care plan said the resident was under the care of a consultant psychiatrist. and had last been seen by the consultant psychiatrist in January 2012.

Judgment:
Non Compliant - Moderate

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:**
Residents’ opportunities for new experiences and social participation were limited.

The person in charge outlined that five of the 27 residents attended a full-time day service which was based on the campus. Ten other residents attended the day service for two hours per week each. However, the other residents were not always facilitated to participate in an activities programme that was based on an assessment of individual need, capacity and preference.

The person in charge outlined that there was 0.5 whole time equivalent (WTE) staff who came to the centre to facilitate activities. Residents in the centre had access to a bus that could accommodate two to three residents at a time, all of whom required one-to-one staffing. Staff said that residents went bowling or to the cinema or out for their tea.

During the inspection staff were observed engaging positively with residents at all times. A number of residents had hand massage and beauty therapy and staff also arranged a “karaoke” session for residents on the afternoon of the first day of the inspection. However, residents were observed spending long periods of time not engaged in any meaningful activities throughout their day. The activity records for one resident kept over a two week period included activities like “chatting” on seven days, “TV” (two days), a “walk around the grounds” (one day), family visiting (two days). Another resident’s activity record included “TV”, “music” and “books”. The provider had completed an annual review on 7 September 2016 of the safety and quality of care and support provided in the centre. This review said that “there was little variation in the choice of activities............introduction of other activities needs to be considered”.

**Judgment:**
Non Compliant - Moderate

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### 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):**
No actions were required from the previous inspection.
Findings:
Due to the nature of information submitted to HIQA, the inspection had a particular focus on the area of food and nutrition and mealtimes. Guidelines and care plans to support residents at mealtimes were not always being followed.

The main evening meal was prepared on a separate site elsewhere on the campus and delivered to the centre from Monday to Friday. This evening meal was then re-heated and staff adapted the meal to accommodate individual residents’ food preferences or dietary requirements. Staff said that the evening meal started around 16:30hrs. On the first day of the inspection, in one of the bungalows, the evening meal started to be served to some residents at 16:45hrs. Staff said that on Saturday and Sunday they prepared the evening meal themselves.

Staff said that residents had a snack before bedtime. The inspector was told that this snack could be a sandwich and a cup of tea or a piece of cake and a cup of tea. In one of the bungalows staff said that seven of the 12 residents were in bed each night before 20:30hrs.

The morning routine in the same bungalow was generally that three residents were up before 08:30hrs and had their breakfast. These were the residents who may be attending day service. The remaining nine residents were supported to get out of bed and have a shower each morning. Due to residents’ dependency levels it required two staff to support each resident at this stage of the morning. Breakfasts for these residents was observed to start at approximately 10:00hrs. In one case the inspector observed a resident starting their breakfast at 10:45hrs. The person in charge said that this resident had stayed up later on the previous evening.

Lunches were prepared on site and staff said that it generally consisted of soup, sandwiches and a drink. Lunch was served at 13:00hrs.

Due to some residents’ dependency levels, staff assisted these residents with their meals. Staff were observed assisting residents in a sensitive manner and engaged in a positive way with residents throughout the meal. Some residents required support for a long period of time to eat their meal. Due to the level of support from staff required and the length of time residents required to eat their meals, the timing of meals required review to provide assurance that residents had access to meals, refreshments and snacks at all reasonable times.

A number of residents had dysphagia (eating, drinking and swallowing difficulties) and had recommendations in place following an assessment by a speech and language therapist. However, staff were not always following recommended guidelines in relation to food and nutrition. For example, two residents had an assessment of their feeding eating and drinking and swallowing (FEDS) completed by the speech and language therapist. These assessments had recommendations regarding positioning of the resident while eating. While the inspector was in the dining room these recommendations were not being followed by staff.

Residents had their weight checked and recorded by staff, on a monthly basis. Staff said
that if a resident’s weight decreased, the resident was referred for review by the dietitian. There was evidence in the healthcare files of residents having nutrition assessment and recommendations from the dietitian.

A number of residents required feeding via a percutaneous endoscopic gastrostomy (PEG) tube, or directly into the stomach. There was a checklist that was completed daily for the care of the PEG.

The person in charge outlined that there was a service general practitioner (GP) who reviewed residents, as required, in the centre. The inspectors reviewed a sample of resident healthcare files and found evidence of regular GP reviews. There were up-to-date records of referrals to consultant specialists maintained for all residents.

Residents in the centre received a community epilepsy outreach service, coordinated through the neurology and epilepsy department in Cork University Hospital. The epilepsy outreach service was established in 2014 to provide high-quality specialist epilepsy care to people with intellectual disabilities living in residential care. The epilepsy outreach service visited residents in their home environment and provided ongoing telephone-based care in between visits.

**Judgment:**
Non Compliant - Moderate

### Outcome 12. Medication Management

*Each resident is protected by the designated centres policies and procedures for medication management.*

### Theme:
Health and Development

### Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

### Findings:
Medication management policies and practices were satisfactory. However, some improvement was required in relation to how medicines were being administered.

Medications were dispensed by a local pharmacist who was also available to staff for advice as required.

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

During the medication administration round inspectors found that appropriate checks
were not always being undertaken by nursing staff to ensure the right medication was administered to the correct resident at the correct time. Some nursing staff were not checking the prescription sheet but were checking the administration sheet. This practice did not ensure that medication was administered as prescribed.

The management of Schedule 2 controlled drugs was checked and deemed correct against the register in line with legislation and the centre policy. Nurses were checking the quantity of medications at the start of each shift.

There were a number of residents who required the administration of emergency medication. Each medicine so prescribed was outlined in the prescription sheet. There were also separate protocols in place, signed by the GP, to give more detailed guidance to staff on the administration of the emergency medication.

**Judgment:**
Substantially Compliant

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**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):**

No actions were required from the previous inspection.

**Findings:**

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

The person in charge was a registered nurse and had been the manager of this centre for a number of years. The person in charge was also responsible for another designated centre managed by COPE Foundation in Cork city. Due to the size and layout of this centre and the complexity of the healthcare needs of some residents, the inspector was not satisfied that the person in charge could ensure the effective governance, operational management and administration of both designated centres. In particular for this centre of the 10 outcomes inspected, one was at the level of major non-compliance, seven were at moderate non-compliance and one was substantially compliant.
The service provider had ensured that a formal annual review of the quality and safety of care of the service had taken place in January 2016. The review that was made available to the inspector concentrated on one of the bungalows and was found to be comprehensive.

**Judgment:**
Non Compliant - Moderate

**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):**
No actions were required from the previous inspection.

**Findings:**
The number of staff required review to ensure that the assessed needs of residents were being met.

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

While the residents’ personal care was very well attended to, it was not demonstrated that staffing levels were sufficient to meet residents’ social needs, particularly in terms of activities or outings.

The staff rota was made available to the inspector and it was noted there was a full complement of staff on duty on the two days of the inspection. During the two days of the inspection the staff rota for one of the houses had three nurses and two care assistants on duty to support 12 residents. Many of these residents required two staff to support them for activities of daily living like dressing, washing and eating. Staff said that to support residents with these activities, particularly assisting people to get out of bed, washed and dressed took approximately 30 to 45 minutes before the resident was ready to have their breakfast. Many of the residents required individualised support from staff to assist them to have their meals, which could take between 20 and 30 minutes.

Each resident required one-to-one support from staff if they were going on an outing. For example, if two residents left one of the houses for a social activity it meant that there were three staff left to support the remaining 11 residents. This was particularly so
on the weekend when day service was not available to residents. In addition, on the weekend, staff had to cook all the meals for residents in addition to their other duties.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A single aspect of this outcome was reviewed relating to the management of healthcare information. The system of records management did not adequately ensure that relevant healthcare information was available to plan care for residents.

In healthcare files seen by the inspector relevant documentation was filed in a haphazard manner in the back “pocket” of the healthcare record. This included results of blood tests, appointment records and letters from healthcare professionals. In one resident’s healthcare file the most recent consultant specialist review was hidden behind other documentation.

Original healthcare appointment records were being filed in the house communication diary. While these appointments were also being documented in the progress and daily notes for the resident, they did not always inform a care plan in the resident’s healthcare records.

At times there was contradictory information on file for the same resident. For example, one resident had recommendations on file from a consultant specialist. Three of the items had been crossed out as part of one care plan. Later in the same healthcare file the original letter was in place with the three items in situ.

The provider had completed an annual review on 7 September 2016 of the safety and quality of care and support provided in the centre. In relation to the management of healthcare information this review said that “one central point of information should also
be considered as not all the information relevant to one person is in place. Care plans could be reviewed and consideration given to be more user friendly”.

Nursing staff were observed to administer medication to a number of residents in a modified form to that prescribed (i.e. crushing an oral medication that was in tablet form) and therefore the medicinal products were being used outside the licensed conditions. These medicinal products were prescribed to be crushed by the medical practitioner on the prescription sheet. However, there was no guidance available to nursing staff in the medication policy in relation to crushing medication; some staff were observed to crush the medication as dispensed in its pouch format; other staff were observed to use a mortar and pestle.

**Judgment:**
Non Compliant - Moderate

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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:**

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

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by COPE Foundation</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003295</td>
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<tr>
<td>Date of Inspection:</td>
<td>14 and 15 November 2016</td>
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<td>Date of response:</td>
<td>06 January 2017</td>
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Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of consultation and participation by residents in the organisation of the centre.

1. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
Due to multiple and complex disability and complex communication challenges of the residents we have keyworker meetings where goals are set, advocacy champion meetings and frequent family forum meetings but from January 2017 we will commence quarterly client forum meetings and record same.

Proposed Timescale: 1st meeting by January 31st 2017

Proposed Timescale: 31/01/2017
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Resident’s right to privacy and dignity was not respected by:
• the use of CCTV without adequate measures in place to safeguard the resident
• no evidence of any consultation with the resident about sharing the room
• paint peeling off the wall of one shared bedroom

2. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident’s privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.
Please state the actions you have taken or are planning to take:
1. A multidisciplinary review will take place to ensure adequate measures that safeguard the resident are in place around the use of CCTV. This review will consider the policy that is in place.
2. There will be further consultation with the resident about sharing her room.
3. The bedroom that required attention has been painted.

Proposed Timescale: 28/02/2017

Outcome 05: Social Care Needs
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement
in the following respect:
The review of the personal plan was not multidisciplinary.

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:
The yearly review of resident’s personal plans will be multidisciplinary.
Personal plans will identify individual needs, choices and aspirations

Proposed Timescale: 30/04/2017
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Plans did not adequately identify individual needs, choices and aspirations.

4. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident’s wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
Currently we meet with the client and the family annually for PCP meetings and this is recorded.
Future personal plan reviews will include the participation of the resident and their representative.

Proposed Timescale: 30/04/2017
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident had a “skills development plan” that had been reviewed in January 2016. The plan outlined that the resident was to be motivated “to continue practising the skills they have”. However, this plan had been unchanged since 2012.

5. 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 will ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments. PIC is commencing with one support plan and reviewing the way it is presented. She will complete one plan by 31/01/2017

Proposed Timescale: All plans complete 31/04/2017

Proposed Timescale: 30/04/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive procedures were not in line with national policy, evidence based practice or the organisation’s own policy.

6. **Action Required:**
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
Restrictive procedures at the designated centre will be reviewed. This review will consider organisational policy, national policy and best practice guidelines.

Proposed Timescale: 28/02/2017

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The behaviour support plan for one resident was not up-to-date

7. **Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents’ behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
All behaviour support plans will be reviewed as each care plan is being reviewed. Restrictive procedures at the designated centre will be reviewed. This review will consider organisational policy, national policy and best practice guidelines.
Proposed Timescale: 30/04/2017

**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:**
Residents were observed spending long periods of time not engaged in any meaningful activities throughout their day.

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

**Please state the actions you have taken or are planning to take:**
The provision of activities at the designated centre will be reviewed to better facilitate residents access to meaningful activities.

Proposed Timescale: 28/02/2017

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Guidelines and care plans to support residents at mealtimes were not being followed.

**9. Action Required:**
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

**Please state the actions you have taken or are planning to take:**
The PIC will put systems in place to ensure guidelines and care plans to support residents at meal times will be followed.

Proposed Timescale: 31/01/2017

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Due to the level of support from staff required and the length of time residents required to eat their meals, the timing of meals required review to provide assurance that
residents had access to meals, refreshments and snacks at all reasonable times.

10. Action Required:
Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

Please state the actions you have taken or are planning to take:
Meal times are currently staggered due to high dependency needs so all meal times vary.
The PIC will review the roster. This will allocate a number of day staffs start time to 8am. This will offer the choice of earlier breakfast for residents if required.

Proposed Timescale: 31/01/2017

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:
Some nursing staff were not checking the prescription sheet but were checking the administration sheet. This practice did not ensure that medication was administered as prescribed.

11. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
All staff nurses have completed their HSE land medication management for 2016. PIC will do a supervision session with all staff nurses to ensure best practice is adhered to.

Proposed Timescale: 31/03/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the size and layout of this centre and the complexity of the healthcare needs of some residents, inspectors were not satisfied that the person in charge could ensure the effective governance, operational management and administration of both designated centres.
12. **Action Required:**
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**
The Registered Provider will review the management of the designated centres.

**Proposed Timescale:** 31/01/2017

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The number of staff required review to ensure that the assessed needs of residents were being met.

13. **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:**
Staffing at the designated centre will be reviewed to ensure the agreed complement of staff is present

**Proposed Timescale:** 31/01/2017

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**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no guidance available to nursing staff in the medication policy in relation to crushing medication; some staff were observed to crush the medication as dispensed in its pouch format; other staff were observed to use a mortar and pestle.

14. **Action Required:**
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.
Please state the actions you have taken or are planning to take:
Advice from Pharmacist stated there was no pharmacological reason why one method of crushing is better than the other. Both are satisfactory. This will be included in the medication management policy when it is reviewed.

**Proposed Timescale:** 31/01/2017

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect: The system of records management did not adequately ensure that relevant healthcare information was available to plan care for residents.

15. **Action Required:**
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
There will be a systematic review of all records One file to be completed by 31/01/2017

**Proposed Timescale:** 30/04/2017