Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Cork City South 1
Centre ID:	OSV-0003695
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Liza Fitzgerald
Lead inspector:	Carol Maricle
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
26 July 2017 09:30	26 July 2017 17:00
27 July 2017 09:15	27 July 2017 17:00

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

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

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of this centre. This centre was a designated centre for adults with disabilities that offered a residential service and respite service. The current inspection was scheduled to inform the registration of the centre.

Description of service:
The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. This statement was found at first to not contain an accurate description of the service provided, however, the

provider re-submitted a statement during the inspection and the service was found to provide as it was described in that document.

The centre consisted of three residences which were based in the outskirts of a city, two of which were located side by side. As stated in the centre's statement of purpose, the centre provided residential accommodation, on a seven-day basis or five-day basis, to adults diagnosed with an intellectual disability. In addition, one of the premises operated a respite service from a dedicated respite bedroom.

The first residence was situated in a quiet housing estate which was adapted for purpose. This house opened on a Monday-Friday basis. It had a garden at the front and a walled garden at the rear; both well maintained and the house could accommodate eight people of both male and female gender with intellectual disabilities. The premises consisted of nine bedrooms, including a staff bedroom. The living area had two large sitting rooms and a large communal kitchen and dining area.

The second residence provided residential and respite accommodation to eight adult males diagnosed with an intellectual disability. It was one of two detached residences which was situated in the city environs adjacent to a day service. It had gardens to the rear and side which were well maintained. The residence consisted of eight individual bedrooms and a separate staff bedroom. Seven residents lived at this residence and the eighth bedroom was used for respite purposes. The living area had a sitting room and a large communal dining area off a modern kitchen with separate utility room. A small visitors and music room was situated at the back of the house.

The third residence provided residential accommodation to nine female adults diagnosed with an intellectual disability. It was the second of two detached residences, situated in the city environs. It had gardens to the rear and side which were well maintained. The residence consisted of eight individual bedrooms upstairs and one bedroom downstairs. The living area had a sitting room and a large communal dining area off a modern kitchen with separate utility room and an office downstairs.

Overall, the centre provided, at the time of this inspection, accommodation and support to 23 residents who lived at the centre. There was one vacancy and one bed available for respite. At capacity, the centre could accommodate 25 residents. The respite service was available to three adults who were known to the organisation and accessed respite on a regular basis. In the 12 months prior to this inspection, staff had also supported other individuals known to the organisation, to access respite at this centre on a less frequent basis. The centre was open to further referrals to the respite service as set out in the statement of purpose.

How we gathered our evidence:
The inspectors met and spent some time with 17 residents. They also met with five family representatives. The inspectors read pre-inspection questionnaires received from both residents and family representatives. The following was also reviewed: a sample of residents' files, personal care plans, medicines management, risk

assessments, the complaints log and the premises was viewed.

Practices and interactions between residents and staff were observed. Staff engaged with residents in a respectful manner. Residents invited inspectors into their home and some residents spoke about their lives in the centre. Residents spoke in a positive manner about the staff, the meals on offer, the day service and their access to further education.

Overall judgment of our findings:
Overall, it was demonstrated that the residents were well looked after by staff and that there were adequate systems in place regarding personal planning. However, there were a number of regulations that were not being met.

Some areas of non compliances were identified in relation to:
-the information contained in the contracts (Outcome 4)
-the safety and suitability of the premises (Outcome 6)
-aspects of health and safety (Outcome 7)
-training in behaviour that requires a response (Outcome 8)
-the governance of the centre (Outcome 14)
-the use of resources (Outcome 16)
-staff training (Outcome 17)
-aspects of records and documentation (Outcome 18).

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

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

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

Findings:
There were systems to ensure that residents were consulted with and actively participated in the running of the centre. The privacy of residents was respected. Residents were enabled to exercise choice and control in their life. Complaints were recorded and acted upon.

At the previous inspection, there were a number of findings pertaining to this outcome. Staffing arrangements, although improved, were still an issue at the centre and this impacted on the ability of the residents to choose on a day-to-day basis their preferences regarding departing or remaining at the centre. (This has been commented upon further in Outcome 16).

Staff were observed communicating effectively with the residents and engaging with them in a kind and respectful manner. They treated each resident as an individual and the person in charge and person representing the provider were equally all very familiar with each resident and spoke about their individual interests and routines. The residents were observed departing for outings to the community with the support of staff and relaxing in their living areas. Some residents engaged in discussion and chat with the inspectors and spoke about their day-to-day living, their interests and hobbies. Some of the residents in particular spoke about how they enjoyed having access to their own televisions in their bedrooms. The inspectors met with family representatives and they all spoke highly of the care that their family member was receiving and the respect shown to them and their family member by staff.

Notwithstanding these positive observations, the inspector observed a written instruction for the attention of staff placed on an exit door of one of the premises. The wording of the instruction was not in keeping with the promotion of dignity of the residents. This was immediately withdrawn by the person in charge and she investigated the matter to the satisfaction of the inspector.

Residents had access to advocacy services based within and outside of the organisation. A staff member was appointed with full-time responsibilities in this area and at the time of this inspection this role was being developed. The person in charge told the inspector that one of the residents had completed training in the area of advocacy. There was documented evidence to show that residents were consulted with and engaged in their person centred planning.

Residents took part in regular meetings about the running of their home. The minutes viewed by the inspector indicated that there were standing agenda items, such as safeguarding and fire safety and the residents raised other issues important to them.

The inspectors spoke with a number of residents over the course of the inspection who confirmed their satisfaction with the services received at the centre and they spoke about their interests, routines and other issues like how they liked to furnish their bedrooms.

The centre maintained a complaints policy. A complaints officer was identified within the organisation. The complaints log was reviewed and it was evident that details of complaints were recorded; the actions taken to resolve the complaint; the outcome and signatures of persons involved.

During this inspection, a resident was concerned about an issue and raised this with the inspector. The inspector raised this with the person in charge who immediately investigated the concern and reached a conclusion to the satisfaction of the resident. Furthermore, the person in charge demonstrated learning from this event.

There were systems in place for the safeguarding of the personal finances of the residents. The inspector viewed the processes in place for one resident and the system ensured that staff accurately recorded lodgements, withdrawals and balances. Furthermore, the resident was afforded privacy and choice in how they spent their own money which was in keeping with their abilities. The person in charge informed the inspector that the personal finances of residents had been audited by a staff member based within the organisation. The findings of this audit were not available for the inspector to review during this inspection.

Judgment:
Compliant

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Residents were facilitated to communicate at all times. Where required, there were systems in place to ensure that effective and supportive interactions were provided to residents to ensure their communication needs were met. The actions from the previous inspection were satisfactorily implemented.

There was a policy on communication maintained by the organisation. Staff, with whom inspectors spoke with, were aware of the different communication needs of the residents. The assessment of need and subsequent resident personal plan highlighted the strengths and any difficulties in the area of communication. The majority of the residents were able to communicate verbally and staff were observed engaging in discussion and chat with these residents. Communication passports were on file, where necessary. The organisation employed a team of multidisciplinary staff, including speech and language therapists, to whom residents could be referred to where required.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
Residents were supported to develop and maintain personal relationships and links with the wider community.

Positive relationships between residents and their family members were supported. Residents were supported to meet with family and friends. Families were encouraged to get involved in the lives of the residents. The inspectors met with a number of family representatives throughout the inspection and overall there was a high level of satisfaction in this area.

There was ample space in two of the residences for residents to meet with their family members, although the residents in one residence were somewhat curtailed in this regard. The inspectors spoke with family members about this issue and they told the inspectors that this was not an issue for them nor the residents as the preference of the resident was to leave their home and go out with them.

There was evidence that family members were involved in the residents' personal plan review meetings. Family representatives confirmed these arrangements.

Residents were supported to develop personal relationships. Some of the residents discussed their friendships outside of and within the centre. They confirmed that staff supported them to maintain these friendships.

Internet facilities were available to residents on desktop computers in all three premises. Residents had access to television, the media and local events on in the community. Residents at one premises spoke about a local community event that was taking at the time of the inspection and how they enjoyed attending this annual event.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
There were contracts of care in place. However, improvements were required in detail outlined in the contracts for all residents.

During this inspection, inspectors reviewed a sample of contracts and found that while contracts were in place, the service provided was not specific, for example, some residents were provided with a five day service and others a seven day service. These arrangements were not set out in their contracts.

The contracts were accompanied by organisational documents that set out the fees the organisation was charging to each resident.

The contracts for respite recipients were local documents created by the person in charge in the absence of an approved contract devised by the organisation. Not all of

the contracts for respite recipients were available during the inspection for the inspector to review.

At the time of this inspection, there was a planned admission in progress and the person in charge told the inspector that this process was being conducted on a gradual basis in accordance with the needs of the resident.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There were systems in place regarding the assessment of the needs of the residents and personal planning arrangements. The actions arising from the previous inspection were resolved.

During this inspection, the inspector sampled a number of files relevant those in receipt of residential services and also sampled a number of files relevant to the recipients of a respite service. However, not all of the files pertaining to respite recipients were available for the inspector to review and this has been commented upon further in Outcome 18.

There was evidence to show that a comprehensive assessment of the health, personal and social care and support needs of each resident had been carried out. This was completed by a staff nurse or the person in charge. The assessment of need incorporated the completion of a health check and various screening tools regarding issues such as the potential of malnutrition, pain and falls. Staff also completed a document entitled 'my self-assessment' and this identified needs in areas such as eating and drinking, practical support, well-being and safety and the taking of risks. Since the previous inspection, there had been further advancements in this area. Residents in one particular unit, identified as having increasing needs, had been reviewed by a multidisciplinary team who then determined the need for some of them to have an

environmental occupational therapy assessment. This assessment set out clearly the suitability of their home to their advancing needs. This meant that the person in charge now had or was in the process of acquiring a set of recommendations of adaptations that were required at the premises to meet the needs of the residents. The person in charge showed the inspector an example of such recommendations and demonstrated follow up with the maintenance team on items that could be resolved locally. She was confident that some adaptations would be resolved by maintenance in a timely fashion given the low cost involved. However, others may require approval of funding and this has been further commented upon in Outcome 6. Given that some of the residents were advancing in age there was insufficient evidence to show that an assessment was completed of their continuing need to attend a day service.

There was a system in place across the organisation to ensure that all personal plans had the required input from a multidisciplinary team professionals and that personal planning of all residents was reviewed by this team on an annual basis. The person in charge was highly conversant of the actions arising from these assessments and was able to account for all actions and their timelines. There was also evidence that the resident and their family representatives were involved in a review of their personal plan. Inspectors saw records of personal planning meetings which were attended by residents and their representatives where available.

Residents had access to their personal plans in an accessible format. There was evidence that goals were identified for residents to achieve, and for some residents these was captured in pictorial format and showed, for example, how staff supported a resident to explore their personal history.

The inspector highlighted to the person in charge and person representing the provider that it was, at times, difficult to distinguish between a document whose version control was maintained by staff at the day service and a document whose version was controlled by staff at the centre. Notwithstanding this, the relevant documents were on file. This has been further commented upon in Outcome 18.

With regard to discharges and transfers, there was appropriate reference to the ongoing suitability of residents to reside at their home, given factors such as their age, their assessed needs and the needs of their fellow residents.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
The designated centre was in a good state of repair and provided a homely environment for residents. However, the recommendations relating to the reconfiguration of a bathroom had not been carried out.

The designated centre consisted of three premises which were based in the outskirts of a city. Two of the premises were located next to each other and were described as purpose built and adjacent to a day service. The third premises was located a short drive away in a quiet housing estate which was adapted for purpose. Combined, the three premises were capable of providing a home to 25 residents.

The first two premises were of a similar design and outlay with both having kitchens, dining areas, communal areas, sufficient storage, utility rooms, staff rooms and bedrooms for up to 17 residents. However, it was noted that one bedroom, viewed by an inspector in one of these premises, did not have a bedside locker or a chest of drawers. The person in charge provided a suitable explanation for this and a timeframe for the purchase of such furniture.

Both of these premises had a garden area to the rear and side of the premise which were well maintained. However, this garden area was without fencing which meant that it was not usual for the residents to enjoy access to this area independently of staff. The person in charge identified to the inspector that they hoped to have funding approved that would ensure that all residents could enjoy the rear and side gardens independently. Although there were plans in place to address this, these were not time bound or costed. Furthermore, there were decorative rocks running throughout these gardens, which, given residents' changing needs, posed a risk to residents. This is addressed under Outcome 7.

Bathroom and toilet facilities were also available in both premises. However following an adverse incident involving one resident in a bathroom in one of the premises, an occupational therapist (OT) had made recommendations involving a redesign of this bathroom in February 2017. At the time of this inspection the majority of these recommendations had not been followed through. Consequently the current configuration of this bathroom posed a risk to the resident involved although the provider was taking steps to mitigate this risk where possible.

The third premises of the centre had a garden area at the front and walled garden at rear. Alongside bedrooms for up to eight residents, the premises consisted of a staff bedroom, two sitting rooms, a communal kitchen and dining area, two shower rooms with toilets and a utility room. However, one of the bedrooms in this premises during inspection did not have a bed. This bedroom was, at the time of the inspection, vacant. The person in charge confirmed both verbally and in writing with the inspector that the bedroom would be suitably furnished before the room became occupied.

Overall the three premises presented as a homely environment which were appropriately decorated and had pictures of residents on display throughout. Inspectors viewed a sample of residents' bedrooms which were noted to be spacious and personalised. Residents spoken with were clearly very happy with and proud of their bedrooms. The designated centre as a whole was generally presented in a clean manner during the course of the inspection. However, in one premises it was observed that there were cobwebs clearly visible both internally and externally.

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

Findings:
While efforts were being made to promote the health and safety of residents, staff and visitors in the designated centre, the review and management of risk, fire safety systems and the provision of fire training required improvement.

A centre-wide risk register had been developed which had been recently reviewed. This also contained risk assessments relating to individual residents. However, in an internal safety audit carried out in the centre the days before this inspection, it was found that the risk register did not adequately reflect the risk within the centre. Although the person in charge had reviewed the risk register since this audit, it was found that further improvement was required to ensure that there was sufficient ongoing review of risk.

While reviewing the risk register inspectors noted some specific risks relating to the behaviour of a resident that was rated as a particularly high risk. However from talking with staff members it was clear that such ratings did not reflect the reality of these risks. It was also noted that one resident had a risk assessment in place outlining how the resident might be slow to leave the centre in the event that an evacuation. However this contradicted the information that was contained in the resident's personal emergency evacuation plan (PEEP) where it was indicated that the resident could move quickly and may need encouragement to slow down. Staff members spoken to confirmed the information that was contained in the PEEP was correct.

In addition, inspectors observed some risks present in the centre on the day of inspection which were not included in the centre's risk register; for example, the presence of oxygen in one of the premises and the use of manual key locks on some fire

exits were not included. As highlighted under Outcome 6 the presence of decorative rocks running throughout a garden area posed a risk to residents which had not been assessed or had resulting control measures put in place. The internal safety audit had also highlighted a need for risk assessment training for staff. This is actioned under Outcome 17.

At the previous inspection it was found that not all residents had a fall risks assessment in place. The person in charge and a representative of the provider informed inspectors at the outset of this inspection that this action had been addressed. In the sample of residents' files reviewed, such assessments were found to be in place and had been recently reviewed.

Fire alarm systems, emergency lighting and fire fighting equipment including fire extinguishers were present in the centre. Internal staff fire safety checks were being carried out and documented. Inspectors saw records of certificates of maintenance carried out by external bodies for the fire alarm, emergency lighting and the fire extinguishers. The fire evacuation procedures were on display throughout the three units of the centre.

On the day of inspection fire exits were also observed to be unobstructed. However, on exit doors in two premises of the centre inspectors noted the presence of sliding locks. In one premises the sliding lock appeared defective and in the other premises a staff member told an inspector that this lock was in use. There appeared to be no rationale for the presence of these sliding locks on the fire exits given that manual key locks were also present. Potentially these locks could hinder an evacuation and this issue was highlighted to the person in charge who undertook to address this.

Fire doors were present in two premises of the centre while inspectors sought confirmation from the provider that fire doors of the required standard were present in the third premises. It was noted that some fire doors did not fully serve their function, for example in one premises it was noted that a fire door in a sitting room did not closely fully while in another premises the door exiting a kitchen did not close without noticeable effort being applied. It was also noted that an oxygen cylinder which was present in one premises was not stored behind a fire door.

Residents had PEEPs in place which had been updated since the previous inspection to reflect evacuation procedures for residents with impaired hearing. Fire drills were being carried out at regular intervals. Records were maintained of these drills which included any issues arising along with the duration of the evacuation. However not all of these drills recorded the time of day when these drills took place. This is addressed under Outcome 18.

Inspectors reviewed training records for staff working in the centre. While the majority had received some form of fire safety training previously, it was noted that 10 members of staff were overdue refresher training in this area which included two staff members who were listed as last receiving fire training in 2013. Training records also indicated that most staff had undergone training in hand hygiene since the previous inspection but three staff members were not listed as having undergone such training. This is addressed under Outcome 17.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
There were systems in place to promote the protection of all residents, however, improvements were required in the provision of training for staff in the management of actual and potential aggression, and in residents' care plans.

The organisation maintained policies on the safeguarding of residents and supporting residents whose behaviour required a response. Residents had access to psychiatry, behavioural therapy and psychology on a referral basis. Residents informed the inspectors that they liked living in the centre and felt safe and identified who they would speak to if they had a concern. Intimate care plans were in place for residents. At the time of this inspection, there had been no concerns of a safeguarding nature raised in the 12 months prior to this inspection.

Training records indicated that all staff had undergone safeguarding training. However, continued deficits were noted in the provision of training regarding the management of actual and potential aggression. This was outstanding from the previous inspection. Training records indicated that four members of staff had not training in de-escalation and intervention while a further two staff were also overdue refresher training in area. This training gap had also been identified in an internal safety audit carried out by the provider.

On the second day of the inspection, an inspector was greeted at one of the premises by a resident and further met with a staff member. The inspector was not asked for his or her identification nor asked to sign the visitor book. This issue was attended to by the person in charge immediately when pointed out.

A sample of behaviour support plans were reviewed and improvements were required. A

resident with support needs in this area had a range of documentation to support them in this regard. However, there were numerous documents that were required to be read and the inspector could not ascertain in a timely fashion the proactive, active and reactive strategies.

There were a small number of residents prescribed an 'as required' medicine for behaviours that required a response. The inspector found that in one case, a resident did not have an accompanying support plan to guide the relevant staff members in their administration of this medicine. The person in charge told the inspector that she would review with the relevant healthcare professionals the requirement for this medicine.

Judgment:
Substantially Compliant

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

Theme:
Safe Services

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

Findings:
A log of accidents and incidents was reviewed and it was found that all notifiable events had been submitted within the required timeframe.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:

There were arrangements in place for the residents to have opportunities to experience new opportunities, education and training.

Inspectors saw evidence of and were told by residents and their family representatives that they were engaged in activities both internal and external to the centre, including, seasonal activities, social outings, going shopping and meeting friends.

Residents were supported to pursue education. All residents were reported to attend day service and this was confirmed by them and their family representatives. Some staff accompanied residents to their day service to support them. A resident was supported to independently access a course.

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

Findings:
Residents had access to healthcare services. Each resident had a comprehensive health assessment and defined health goals. Goals were specific and clearly identified any required healthcare checks, appointments or referrals.

Residents had access to a general practitioner (GP), an out-of-hours GP service and consultants as required. Residents were supported, where necessary by staff in attendance at these appointments. Copies of referrals and reports were maintained in residents' files.

Residents had access to allied health professionals including occupational therapy, dietetics, occupational therapy and speech and language therapy. However, there was reference to a lack of timely dietetics services for some of the residents in assessments completed by staff. The timeliness of same was not escalated accordingly to senior management. The person in charge in conjunction with the person representing the provider informed the inspector that there were no residents whose care was being compromised due to a lack of a dietetic service and gave examples to the inspector of the steps staff took to ensure that residents were assisted in their health and nutrition on a day-to-day basis. The person in charge told the inspector she would monitor the referrals made to these services to ensure that this service was in fact required.

Residents had hospital passports contained in their personal plans which outlined key information relating to residents should they be admitted to hospital.

Inspectors were satisfied that residents were supported to buy, prepare and cook their own food necessary with appropriate facilities provided for this. Residents also had accessed to snacks and refreshments if required. Inspectors saw a meal choice board displayed at a premises and there was a written record of meals provided to residents.

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:
Procedures were in place relating to medicines management but it was noted that a number of practices required formalising in a centre specific policy.

The organisation maintained an organisational policy on medicines management and there was a local centre specific policy to complement the overall policy. The local policy however was not signed or dated. It did not contain guidance for staff to follow on the arrangements regarding the respite service and also issues, such as, the administration of medicines to residents when they were at their family home or out on day long activities. There was a risk that medicine would be administered outside of the prescribing regime as staff used empty medicine containers to store medicines sent home with the resident. A medicine found in the cupboard of a premises was prescribed to a resident living at a different premises. Although the explanation for this arrangement was provided to the inspector the arrangement was not set out in writing.

Samples of prescription and administration records were reviewed by inspectors. It was found that the required information such as the medicines' names, the medicines' dosage and the residents' date of birth were contained in these records. Prescription charts were dated within six months. The records viewed by an inspector indicated that medicines were administered at the time indicated in the prescription sheets.

A fridge for storing medicines was available in the centre.

A medicine given as a PRN (medicines taken as required) did not have an accompanying support document The person in charge committed to reviewing this immediately and

later confirmed that the medicine has not been administered in 12 months and that she would review the necessity of this medicine to be prescribed and or arrange for the appropriate documentation be drawn up. This has been actioned under Outcome eight.

A secure cupboard was in place for the storage of medicine. However, it was clear that the size of this cupboard was too small for the contents. The height of the shelves meant that a staff member had to climb on a chair to retrieve items (which was cumbersome). The person in charge was asked to review this.

Each resident had their own medicines storage container which were also too small and this resulted in their medicines being stored loose in the cupboard. Notwithstanding these arrangements, all medicines viewed by the inspector were labelled appropriately.

The location of the separate space available for out-of-date or returned medicines was not clear from the outset, however, this was later resolved by the person in charge. An antibiotic was found in the medicines cupboard and this was described in writing as an antibiotic for stock purposes. The person in charge confirmed to the inspector that it was not usual policy for a stock of antibiotic to be kept on site and resolved the issue immediately.

Some residents were prescribed a rescue medication used in the event of a seizure. Specific training was required to administer this medication. The training records showed that four care assistants did not have this training completed.

There was no system in place to ensure that residents were assessed in their capability to self-administer medicines. This was especially pertinent given that a resident was reported by the person in charge to self-administer medicine in their family home. It was also relevant for the respite recipients whose usual place of residence was their home and only through such an assessment could it be ascertained whether they had the capacity to self-administer.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:

Inspectors reviewed a copy of the statement of purpose and found it was not specific as regards the respite service provided. Following completion of this inspection, an updated statement of purpose was submitted to HIQA which accurately reflected the service provided.

The statement set out the aims, objectives and ethos of the centre. It confirmed management and staffing arrangements.

This centre comprised three premises, two of which were detached and located side by side. The third premises was a semi-detached house located a short distance away. The total capacity of this centre was 25 residents. One of the houses offered a respite service and this was set out in the statement.

The statement had been reviewed within the previous 12 months.

Judgment:
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:
There were adequate systems in place to govern the centre. There was a clear management structure. Some improvements were required in the annual review of the centre and the unannounced six-monthly inspections. At the previous inspection, there had been a number of non compliances found in this area and an action plan response had been accepted by HIQA. At this inspection, these actions were seen to have been completed.

The management system at the centre was clear. Care assistants reported to nursing staff who in turn reported to the person in charge. The person in charge reported to the person representing the provider. During interview, staff were clear about who was in charge and the management structure. On-call services were provided during out of hours and this included access to nursing staff.

There was a schedule of formal staff meetings in place for 2017 and one meeting this year had taken place. There was a gap in the second quarter that the person in charge acknowledged. A staff team meeting for the third quarter of the year had been scheduled. Given that the centre consisted of three distinct premises, the inspector found that the frequency of the meetings required review.

A performance management development system was in place at the centre, however, the organisation did not yet have a policy developed for supervision.

The person in charge maintained a folder of audits and a number of areas of practice had been audited in the 12 months prior to this inspection, such as, food safety, personal and intimate care, fire safety, infection control and nurse-led audits on medicines management. The person in charge was conversant with all actions arising and shared with the inspector the findings and actions arising.

The provider had completed a six month regulatory unannounced inspection to each unit comprising the designated centre within the previous six months but an earlier visit to all premises (six months earlier) had not been conducted. The person representing the provider acknowledged that there was a gap in the completion of these inspections.

The inspector reviewed the reports arising from such visits and found that an action plan had been generated for two of the premises while the third premises did not have an action plan generated to account for the failings identified in the report. Notwithstanding this finding, the person in charge was able to provide an update on each action arising from each report and the majority of the actions had been completed while some were in progress.

This centre comprised three premises and the provider produced three annual review reports in 2016 reflecting each premise. However, one was completed within the 12 months prior to this inspection, while two had been completed outside of this time-frame. This meant that overall the provider was not in compliance with this regulation. Two of the three reviews included the viewpoint of the residents, however, one did not explicitly state this information.

The centre was managed by a clinical nurse manager (the person in charge). She had the relevant experience, displayed good leadership during the course of the inspection and was fully conversant with the needs of the residents and the arrangements of all three premises. She had an appropriate knowledge of the regulations and requirements. She had addressed a significant number of actions arising from the previous inspection.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
The provider was aware of their responsibility to notify HIQA of the absence of the person in charge where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days of more, whether planned or unplanned.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
The centre had a number of resources to ensure that residents received support and care in accordance with their needs, however, there were some gaps identified and the plans to address resource issues at the centre, such as, staffing arrangements and opening hours of each premises were not finalised in writing.

During this inspection, the residents were observed departing for social outings in groups and told the inspectors about how much they had enjoyed their outings. However, some spoke about their preferences to go places or meet with people and cited staffing as one of the factors in the decision making around this. The person in charge, during interview, with the inspector, stated that for pre-planned activities extra staffing could be and was always sought to ensure that a resident could be facilitated in this manner. However, the residents did not have the same flexibility for unplanned activities.

The staff ratio arrangements were set out in the statement of purpose. During the inspection, staff were found to be busy yet able to meet the needs of the residents. There was, however, on file, correspondence from the multidisciplinary team to the senior management team that set out a statement around staffing and how it was an issue at the centre. Reference to staffing arrangements had also been made by staff in

their referrals to healthcare professionals. During meetings with residents and their representatives, staffing levels were not raised as an issue.

The person representing the provider informed the inspectors that staffing arrangements across all designated centres had been reviewed by a senior management team within the organisation. The results of this review were not yet finalised at the time of this inspection. However, it was confirmed, that the preliminary results of this review highlighted that one of the premises did have a deficit in staffing numbers that limited the residents to always have the opportunity and choice to engage in pursuits by themselves with the support of staff; without the need for this to always be pre-planned. As an interim measure, additional staff were rostered to this premises to promote residents engaging in activities. This was confirmed by the person in charge who gave examples of when extra staffing was assigned and showed evidence of same on the staffing rosters. Family representatives told the inspectors that they had no concerns in this area.

The centre was unoccupied during the day-time hours that the residents attended day service. Staff members accompanied the residents to their day services or commenced their shift upon the return of the residents from day service. Should there be a reason as to why a resident could not attend their day service or indeed had to come home unexpectedly then this information was made known to the person in charge who scheduled staff to work at the centre or she herself opened up the centre during these hours and tended to the needs of the residents. In the long-term, both the person in charge and the person representing the provider stated that this model would not suit the changing needs of the residents, some of whom were reaching or had reached retirement age.

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

Findings:
There were arrangements in place to ensure that there was an appropriate skill mix to

meet the assessed needs of the residents. Residents received continuity of care from a core team of staff. The arrangements in place to supervise staff and volunteers required improvement. Staff did have access to continuing professional development however, as addressed in the previous inspection and noted on this inspection there were gaps identified. Furthermore, staffing arrangements at evening time continued to limit residents' choice in relation to whether or not to participate in activities and options to pursue their individual interests although there had been some improvements in this area. This has been actioned in Outcome 16.

The inspector reviewed the staff training matrix maintained by the person in charge. The previous inspection found training gaps in relation to hand hygiene and food safety. Training records reviewed at this inspection also identified gaps in a number of areas. There were gaps relating to fire safety and the management of actual and potential aggression; these have been already been actioned under Outcomes 7 and 8 respectively but there were also gaps relating to manual handling, food safety, hand hygiene and risk assessment.

Inspectors reviewed a sample of staff files. While most of the required information, including an Garda Siochana vetting and two written references, were provided it was noted that that two files did not contain proof of identity that included a recent photograph.

The centre utilised volunteers and the arrangements in place for the supervision of this role were not robust. The person in charge agreed to review these arrangements immediately following the inspection.

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

Findings:

While the action from the previous inspection was satisfactorily resolved, overall, some improvements were required in relation to the review of the centre's policies, the directory of residents, the guide for residents, records of fire drills and residents' records.

Inspectors viewed a copy of the directory of residents and this did not contain sufficient information on the respite recipients that received services from the centre since their date of admission. However, this was mostly resolved by the conclusion of the inspection and by the person in charge.

There was a residents' guide maintained by the organisation and this did not contained the necessary information, as set out by the Regulations. Furthermore the guide required updating in the staffing and governance arrangements. The resident guide did not sufficiently set out to residents important aspects of the running of their home, such as, a respite service being delivered and the arrangements at other homes when the home of the resident was unoccupied.

The person in charge did not have all of the personal files of the respite recipients available for the inspector to review. Some of these files were on site and they were found to contain the relevant documents. The person in charge accepted that all residents in receipt of respite services required personal planning arrangements on file at the centre.

Some documents kept in the personal files of the residents were documents maintained by staff at the day service they attended. This meant that the inspector had to check with the person in charge the source of the document when reviewing records. The records did not clearly set out, for example, in goal setting whether these goals related to their day service or the goals they set for themselves as part of their personal planning arrangements.

All Schedule 5 policies and procedures, as required by the regulations, were in place, however, some were noted as to be outside of the three year timelines. In addition, the arrangements for the referral and admission of respite recipients to the centre were not sufficiently set out in writing, nor reflected in the organisational policy. A centre specific medicines management policy required updating along with confirmation of the author and date of creation.

As mentioned under Outcome 7 records of fire drills carried out were maintained in the centre but the time of day when the drills took place was not always documented.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003695
Date of Inspection:	26 & 27 July 2017
Date of response:	04 October 2017

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 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contracts for both the respite and residential recipients were not sufficient as they failed to set out in writing all the terms and conditions of the service that a resident received.

1. Action Required:

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

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

Please state the actions you have taken or are planning to take:
Contracts will be reviewed to set out all the terms and conditions of the service that residents receive .

Proposed Timescale: 30/11/2017

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 assessment process used to determine the suitability of the resident to continue to attend their day service was not sufficiently documented.

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

Please state the actions you have taken or are planning to take:
A schedule of reviews and assessment has been created for all residents to determine the commencement and end times the resident attends and ends their day service .

Proposed Timescale: 30/11/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident's bedroom did not have a bedside locker or a chest of drawers.

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

Please state the actions you have taken or are planning to take:
A bed side locker has been obtained for this bedroom. A chest of drawers will be purchased for this room.

Proposed Timescale: 29/09/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One premises of the centre had cobwebs clearly visible both internally and externally.

4. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
Cobwebs internally have been removed.

Proposed Timescale: 29/09/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The recommendations of OT relating to one bathroom had not been followed through meaning the current layout of the bathroom posed a risk to one resident. One resident bedroom did not have a bed present at the time of the inspection. The garden area for two units was without fencing which meant that it was not usual for the residents to enjoy access to this area independently of staff.

5. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
A bed will be provided in the currently un occupied room .
Fencing will be erected in the garden in the first quarter of 2018 .
The works to the bathroom will be completed by end Dec 2017

Proposed Timescale: 31/03/2018

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:

Some risks identified in the centre by inspectors were not included in the risk register. Some ratings applied to specific risks did not reflect the actual level of risk. One risk assessment was noted to contain contradictory information.

6. 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:
The risk register will be reviewed and amended accordingly .Training in Risk assessment will be provided to staff . The Pic will review the register on a regular basis.

Proposed Timescale: 30/11/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An oxygen cylinder was not stored behind a fire door. Sliding locks were present on two exit doors despite their being no rationale for their presence.

7. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
The oxygen cylinder is now stored in a secure room with a fire door.
The doors with sliding locks have had the sliding locks removed.

Proposed Timescale: 27/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Confirmation was required from the registered provider that the doors in one premises of the centre provided sufficient containment in the event that a fire occurred and some fire doors did not close fully.

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

Please state the actions you have taken or are planning to take:
Doors which were not closing properly have been repaired and are now closing properly. The provider is undertaking a survey of all doors to identify where doors are

in place and where doors are required .

Proposed Timescale: 30/11/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff were overdue refresher training in fire safety.

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

Please state the actions you have taken or are planning to take:
A proposed date of the 26/9/2017 has been suggested for refresher fire training. Awaiting confirmation of same from safety officer who is in correspondence with the training company

Proposed Timescale: 26/09/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were training gaps in relation to de-escalation and intervention.

10. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
Since inspection one staff has been trained in management of behaviour that is challenging including de-escalation and intervention techniques 17 th & 18th August 2017.
A matrix of training staff has highlighted two further staff who need training. PIC has requested dates for this training.

Proposed Timescale: 30/11/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documents to guide staff on proactive, active and reactive strategies for one resident were difficult to retrieve. A resident did not have a support document in place for staff to follow in their consideration of the use of a chemical restrictive practice.

11. 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:
This resident and residents file has been reviewed by the psychiatrist. Psychiatrist discontinued PRN medication as it had been a number of years since it was last administered. File updated to reflect appropriate changes.

Proposed Timescale: 24/08/2017

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:
The residents did not have an assessment completed of their ability to self-administer medicines.

12. 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:
PIC has commenced assessment of residents to self-administer medication

Proposed Timescale: 13/10/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a risk that medicine would be administered outside of the prescribing regime as staff used empty medicine containers to store medicines sent home with the resident.

13. 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:
PIC arranged pharmacy audit by community pharmacist August 2017.
Local medication policy for the area has been amended to reflect ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is labelled and stored securely.
In conjunction with the pharmacist the monthly pharmacy order (review and request) will now reflect that medication order is separated in half. This allows for sending home medication in labelled container ordered from pharmacy and packaged by pharmacist. Currently this applies for only one resident.

Proposed Timescale: 11/09/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The medicines cabinet was cluttered and the shelving was hard to reach.

14. Action Required:
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
Medication press has been requested by PIC to be moved to another area within the residence, where more room is available with easy access.

Proposed Timescale: 29/09/2017

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:
The provider had not visited the centre on two occasions to carry out an unannounced six monthly inspection in the 12 months previous to this inspection.

15. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the

designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
An Unannounced visit to the centre will be carried out between November2017 and February 2018.

Proposed Timescale: 28/02/2018

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider did not have a formal system of supervision in place.

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

Please state the actions you have taken or are planning to take:
A supervision policy will be developed and implemented in the Organisation.

Proposed Timescale: 31/12/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The timeframe for completion of an annual review of the centre was not in adherence with the Regulations.

17. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
Annual Review will be completed by the end of October 2017

Proposed Timescale: 31/10/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not explicitly stated in one of the reviews that the viewpoint of the resident had been ascertained.

18. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
PIC will ensure that residents views are recorded and the resident given the option of signing the recorded information. Resident will be supported by staff (keyworker).
A schedule of review of residents files has been formulated by PIC

Proposed Timescale: 31/01/2018

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The plans to address resource issues at the centre, such as, staffing arrangements and opening hours of each premises were not finalised in writing.

19. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
A staffing review is underway in the Organisation. This will address resourcing centres to ensure effective delivery of care and support

Proposed Timescale: 30/11/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two staff files were noted not to contain proof of identity that included a recent photograph.

20. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
Up to date photo I.D has been requested for personnel files for all staff in designated centre

Proposed Timescale: 15/09/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were training gaps in relation to manual handling, food safety, hand hygiene and risk assessment.

21. 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:
PIC has scheduled manual handling for two staff on 17/11/17 .
Food safety training has been requested for staff who are outstanding training in this area. Training is scheduled for October 2017.
Hand hygiene training will be completed by 30/9/2017.

Proposed Timescale: 17/11/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The arrangements for the supervision and support of volunteers were not robust.

22. Action Required:
Under Regulation 30 (b) you are required to: Provide supervision and support for volunteers working in the designated centre.

Please state the actions you have taken or are planning to take:
At present there are no volunteers in the centre . Where volunteers are placed in the centre the Organisational Policy on Volunteers shall be implemented .

Proposed Timescale: 11/09/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all of the policies maintained by the organisation had been reviewed within three years. Staff required a centre specific policy on admissions relevant to the respite service that was provided at the centre. They also required an updated centre specific policy on the arrangements for medicines management.

23. Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
Policies and Procedures maintained by the Organisation are currently being reviewed . A centre specific admission policy relevant to the respite service provided at the centre will be developed by the PIC . A centre specific medicines management policy has been updated.

Proposed Timescale: 30/11/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residence failed to include the necessary information relevant to respite recipients.

24. Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
The directory of residents has been amended. All people who have availed of a respite service within the last year have been included in the directory of residence.

Proposed Timescale: 27/07/2017

Theme: Use of Information

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

Not all records of fire drills documented the time of day when drills took place.

25. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
PIC has displayed a notice for all staff carrying out fire drills to include time of fire drill in log book. Pic will audit records of drills to ensure time of drill has been included.

Proposed Timescale: 30/09/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge did not have available for the inspector the personal planning arrangements and assessments of need for all respite recipients.

26. Action Required:
Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

Please state the actions you have taken or are planning to take:
PIC has commenced personal planning and assessment of need of all respite recipients who avail of respite in the designated centre.

Proposed Timescale: 20/10/2017