Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Cork City North 15
Centre ID:	OSV-0005395
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):	Conor Dennehy
Type of inspection	Announced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
30 August 2017 10:30	30 August 2017 19:00
31 August 2017 08:30	31 August 2017 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 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 centre was a designated centre for adults with disabilities that offered a residential service. This was the second inspection of this centre since it had been reconfigured as a standalone centre in 2016. The centre had previously been part of a larger centre in 2014 and 2015.

The current inspection was scheduled to inform the registration of the centre.

How we gathered our evidence:

As part of the inspection, the inspectors met and spent time with two residents and three family representatives. Not all of the residents wanted to or were able to converse with the inspectors, therefore the inspectors met briefly or observed staff interactions with the remaining 16 residents. The inspectors also met a number of staff that included nurses and care assistants, the person in charge, two persons involved in the management of the centre and the person representing the provider. The inspector read documentation such as a sample of residents' personal plans, pre-inspection questionnaires submitted by residents and their representatives along with other relevant records kept in the centre.

Description of the service:
The provider had produced a document called the statement of purpose, as required by the regulations, which described the service provided. During and immediately following this inspection, the person representing the provider made a number of changes to the statement of purpose to ensure that it accurately reflected the service that the centre provided. The statement of purpose identified that the centre catered for adults with a diagnosis of an intellectual disability and or autism. The maximum number of residents that the centre could cater for was 18 and, at the time of this inspection, the centre had no vacancies. The inspectors found that the service was being provided for as it was described in the document.

The centre comprised three purpose built bungalows on a campus style setting on the outskirts of a city. Each of the houses had a kitchen, a living room, a dining room, a music room, separate laundry facilities, bathroom facilities and bedrooms accommodating each resident.

Overall judgments of our findings:
Overall, it was demonstrated that residents were supported appropriately on a day-to-day basis in their health and personal planning arrangements by staff, however, there were a number of regulations that were not being met.

Some areas of non compliance were identified in relation to:

-an aspect of dignity (Outcome 1)
-provision of internet facilities (Outcome 2)
-terms, conditions and admissions (Outcome 4)
-personal goal setting (Outcome 5)
-suitability of the location of a medicines storage unit (Outcome 6)
-fire safety and risk assessment (Outcome 7)
-restrictive practices (Outcome 8)
-education and learning (Outcome 10)
-aspects of healthcare (Outcome 11)
-aspects of governance (Outcome 14)
-supervision (Outcome 17)
-records and the directory of residence (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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The rights of the residents were promoted and their dignity was upheld. Residents were consulted about the running of the centre. There were systems in place for advocacy. The organisation had a complaints system in place. The action arising from the previous inspection had been addressed. An improvement was required regarding kitchenware at one of the units.

There were systems in place to ensure that residents were consulted about the running of the centre. The inspector viewed documentation that showed staff members consulting with residents (in an individual manner) each month. It was not always clear to the inspector that the information written on the questionnaire was provided by the resident as the staff member did not always note that they completed the document on their behalf. This was brought to the attention of the person in charge during the inspection. The management team had arranged a family forum day once in the 12 months prior to this inspection and as part of this forum, all representatives were asked to give their views on the service, both in person and in writing.

There were systems in place to promote advocacy. The provider had employed a staff member with a full-time role in this area. A resident had attended training in advocacy and a staff member had been recently appointed to the role of advocacy champion for this centre. These systems were in their infancy at the time of this inspection, however, an advocacy roadshow was planned in the coming months to take place at the centre, to which all residents would be invited to participate.

There were policies and procedures in place regarding the management of complaints.

All complaints were documented in writing, following the system established by the provider. The provider maintained a complaints policy. There was an easy-to-read version of this policy available to all residents and posters displayed around each unit of the centre informing residents of how to make a complaint. There had been a number of complaints received in the 12 months prior to this inspection and each complaint was recorded in writing and included the following information; date received, nature of complaint, actions taken to reach a resolve and the satisfaction of the complainant following the resolve. The management team were cognisant of any pattern and trends arising and could account for each complaint and its resolve. The inspector asked the person in charge to review a particular pattern of complaints received in respect to whether they overall constituted as a safeguarding concern. This was attended to immediately by the person in charge and the designated officer during the inspection to the satisfaction of the inspector. This has been further referenced in Outcome 8.

During this inspection, staff were observed treating residents well and upholding their dignity. Some staff were allocated a key worker role and staff team meeting minutes showed that the nature of this role was explained and reinforced to staff in the recent months. During interview, staff spoke positively about the residents, they were clear about the needs of each residents, their strengths, their goals, their likes and dislikes. Staff were observed to be very welcoming about representatives calling to the houses to visit the residents. During interview, representatives reported that staff were welcoming to them when they called. There was sufficient space in each unit for the residents to meet with their representatives alone.

During this inspection, an inspector observed that the quantity, quality and location of personal cutlery and tableware for a resident was not suitable. The rationale for the storage of these items separately to that of their peers was appropriate. However, the manner in which this was done was not entirely suitable and did not promote the dignity of the person. The person in charge committed to reviewing this immediately following the inspection.

Some of the residents were observed to have their own interests outside of the centre and were facilitated by staff to enjoy these. An inspector spoke with a resident who confirmed that he or she was assisted by staff to attend a day centre, under the auspices of a separate organisation. A resident showed an inspector their specialised skills in arts and crafts from their day service located on the same campus of the centre.

Residents were supported to maintain control over their own possessions. Each resident had a personal inventory of possessions. However, the inspector observed that some staff recorded the audit of personal possessions differently to others and the person in charge agreed to review this to ensure accuracy going forward. It was observed by the inspector in the minutes of a staff team meeting that the results of an audit, conducted by a representative of the finance office, showed that that personal spending conducted by residents varied from resident to resident. Key workers were reminded of the monies available to each resident and how all residents should be offered opportunities to spend or save their monies in accordance with their needs and preferences. An inspector met with a resident who conveyed satisfaction in how their finances were maintained by staff.

Judgment:
Substantially Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
Residents were supported in their communication; however, an improvement was required with regard to residents' internet access. Furthermore, the provider's own audit of meal times had identified a need for visuals at the centre at the weekend regarding meal choices; this was not in place.

The provider maintained a policy on supporting residents in their communication. There was a speech and language therapist service available to residents as part of the suite of services provided by the organisation. Staff also had access to continuing professional development in the area of augmented forms of communication.

Each resident had their own personal planning arrangements set out and these arrangements included a written record of the abilities of each resident in how they communicated in addition to the needs of the residents in this area. This section of the plan was generally written by care staff as they had a close relationship with the resident. The records viewed by the inspectors showed how staff wrote a detailed record of how each resident liked to communicate including their use, if any, of established communication methods. Some residents had developed their own communication style using gestures, pointing, body language and their own adaptations of established forms of communication. There were pictures of some of the residents demonstrating their use of gestures and signs and this acted as a guide for staff. Residents had communication passports, where applicable, and staff were aware of the purpose of same.

A resident had been assessed as to their requirement, or not, of an enhanced hearing aid appliance and the decision-making around this was not entirely clear. A person involved in the day-to -day management of the centre committed to reviewing this need in line with organisational policy. This has been further referenced in Outcome 16.

The person in charge supported staff to attend external courses in augmented forms of communication and a number of staff had completed training in this area. In addition, the person in charge confirmed to the inspector that further in-house training on communication methods had been planned for the final quarter of the year which staff

would attend, evidence of which was shown to the inspector.

At the time of this inspection, there were internet facilities available to residents; desk top internet facilities were available at the main office and day centre. However, easy access to these facilities was not always available to each resident in their home. A resident told the inspector that he or she was awaiting internet facilities in order to communicate with a family member abroad. The person in charge demonstrated progress in this area and accepted that all residents should have these facilities in place at their home.

The needs of some of the residents were such that they required a high level of support from staff in their eating and drinking. Where required, each resident had their own individualised eating and drinking regime (as prescribed by a speech and language therapist). This information was displayed in each centre for all staff to see. During interviews, staff members could articulate the regimes of each resident

The annual review of the centre stated that residents were provided with visuals of meal choices available to them during the week, however, these visuals were not available at the weekend. This was acknowledged by the person in charge as a gap.

Judgment:
Substantially 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 in developing and maintain relationships in the community.

Overall, each resident inspectors met with stated that they were supported, as appropriate, to maintain relationships with their friends and family.
The organisation maintained a policy on visitors. There was a high level of satisfaction expressed by the representatives of residents in this area and they appreciated the open door policy of the centre while stating that they were always made to feel welcome by staff.

The staff team consisted of a number of care staff that had dedicated responsibilities to enable residents to access the community on a day-to-day basis. Staff told inspectors that, in general, they had the staffing and vehicle resources to ensure that residents

were facilitated in this manner. They set out set how residents liked to attend events that took place, for example, theatrical productions.

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:
The organisation maintained a policy on admissions; however, the policy had not been followed with reference to two recent admissions. At the time of this inspection, the contracts in place between residents and the organisation were reported as not being up-to-date and were awaiting sign off.

During this inspection, the inspectors were informed by the management team that there had been two emergency admissions in the previous 12 months that had not been conducted in line with organisational policy. The rationale for same was set out by the management team and confirmed in records. Some family representatives commented on the manner in which the admissions were planned and executed, stating that they had little time to visit the centre prior to the admission. There was documentary evidence to show that notwithstanding the manner in how these admissions were conducted, both residents were reported to have settled in well and adapted to their new home. Personal planning arrangements had commenced for each resident and were at various stages; all of which was confirmed in writing. The person representing the provider acknowledged that the organisational policy had not been adhered to on these occasions and that this was not usual practice.

The inspectors reviewed the contents of an annual review of the centre conducted shortly before this inspection. The results of the review showed that contracts of care (terms and conditions) were not up-to-date or signed off by all parties. The person in charge stated to an inspector that these issues were still open at the time of this inspection.

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:
The organisation had systems to ensure that personal planning arrangements were in place. The needs of residents were identified and assessed. Each resident had their own personal planning arrangements in place and these were subject to review in conjunction with their representatives. Achievements in goal setting were not recorded in a consistent manner across personal planning arrangements.

At the previous inspection, residents' personal plans were not made available in an accessible format to the residents. Some goals were generic in nature and not specific. At this inspection, these actions had been implemented, although recorded progression against goals was not consistent throughout the files.

There were systems in place to ensure that an assessment of the needs of the residents was completed annually. Each resident had a set of assessments completed in the area of healthcare, eating and drinking, speech and language requirements, positive behavioural support and mobility requirements.

The inspector saw that where needs were identified in an assessment, these needs were then cross-referenced in other sections of the resident's file and set out as health management plans. For example, where skin integrity was noted as an issue in the assessment then a healthcare plan was formed around skin integrity. In general, the nursing staff team maintained responsibilities for the management healthcare management plans and their recording and updating.

An inspector noted that it was the opinion of a professional that a resident required an intensive speech and language programme. However, evidence of this intensive programme having been carried out was not set out in the file of the resident. This resident had already had their multidisciplinary review and this recommendation has not been discussed. This was brought to the attention of the person in charge who committed to reviewing the recommendations of the professional in the first instance and subsequently liaising with the speech and language team.

Each resident, whose file was viewed by the inspector, had a personal centred plan which was a document all about them, their likes and dislikes and goals that they would like to achieve. An inspector met with a resident who could articulate their person centred plan and the goals that they had set for themselves in the coming year.

The inspectors met with a number of representatives. Although, not everyone confirmed their awareness of the term 'personal plan', they confirmed their involvement in decisions regarding the care and support given to residents and how this was usually done both informally and formally.

Each resident had personal planning arrangements (separate to their person centred plan) and this set out a range of information about each resident, such as important information for staff to know, important dates in their year, their likes and dislikes, their abilities in the area of communication, hospital passports and individualised risk assessments.

There were systems in place for goal setting and this showed the effectiveness of personal planning. There were two sets of goals devised, goals devised by the resident during their person centred planning meeting and goals devised by staff as part of the residents' wider personal planning arrangements. The inspector observed that at times there was not a demonstrated link between both sets of goals. The way in which goal progression was recorded was not consistent across files in the year prior to the inspection. However, new documentation had been introduced at the centre and the person in charge was confident that the new methods of recording would ensure greater consistency.

The personal planning arrangements for each resident were reviewed by a multidisciplinary team of professionals employed by the organisation. This was an annual event. The person in charge and persons involved in the day-to-day management of the centre demonstrated appropriate awareness of the outcome of these meetings.

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:
Inspectors were satisfied that the premises provided was suited to meet the needs of residents living in the designated centre.

The designated centre was purpose built and comprised three, six-bedroom self-contained units, two of which were connected by a keypad accessible corridor. Each unit had its own kitchen, dining room, sitting room, music room, bathrooms, laundry room, cleaning room, linen room, toilets, staff changing facilities and an office.

Attempts were made to give the premises a homely feel. For example, the three units were noted to be colourfully decorated and well-furnished with photographs, drawings and paintings on display throughout. Inspectors also saw some residents' bedrooms and noted that these were personalised with space provided for residents to store their belongings.

While in general it was found that the premises was appropriately laid out, it was noted that the provider's own annual review, carried out in August 2017, had highlighted the need for one of the units to have its own fridge for storing medication. It was also observed that in another of the units, a press for storing medication was located in the kitchen area. Inspectors were informed that the suitability of this location had not been reassessed.

Inspectors observed that the designated centre was presented in a clean manner during the course of the inspection and was seen to be kept in a good state of repair.

Judgment:
Substantially Compliant

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

Findings:
Although some efforts were being made to promote the health and safety of residents, staff and visitors in the designated centre inspectors observed four fire doors being held open by furniture while a proactive approach towards risk was not always apparent.

Fire alarm systems, emergency lighting and fire fighting equipment, including fire extinguishers, were present in all three units of the centre. Inspectors saw records of certificates of maintenance carried out by external bodies at the required intervals for

such equipment. Fire doors were also present in the centre but at the outset of the inspection, inspectors observed a fire door being held open by a chair despite the presence of a functioning magnetic lock on the door. Such action would negate the effectiveness of the fire door to contain a fire. This was highlighted to the person in charge who immediately addressed the issue.

However, during the course of the second day of inspection a further three fire doors were observed by inspectors to be held open with furniture in a similar way. As a result inspectors were not satisfied that this practice was being appropriately responded to. Consequently additional assurances were sought from the provider to address this concern which was provided to inspectors the day following this inspection.

Fire drills were being carried out at regular intervals in all units of the centre. A record of these drills was maintained which included key information including the name of staff who participated and the time of day when the evacuation took place. Staff demonstrated a good knowledge of the steps to be followed should an evacuation be necessary. Training records indicated that all staff had undergone fire safety training but some were overdue refresher training in this area. This is addressed under Outcome 17.

The evacuation procedures were on display in all four units of the centre. Fire exits were also seen to be unobstructed throughout. All residents had personal evacuation plans (PEPs) in place which were noted to have been recently reviewed. However, in one resident's PEP it was noted that a specific evacuation technique for a resident was not referenced in the night-time evacuation procedure listed even staff spoken to said that they would use this technique to ensure the safe evacuation of the resident.

A centre-specific risk register was in place which was noted to have been recently reviewed. The register contained details of risk assessments carried out in relation to issues such as manual handling and slips, trips and falls. However, it was noted that the risk ratings applied in some risk assessments required review to ensure that they adequately reflected the actual level of risk within the centre, such as a risk rating applied for residents to go swimming. In addition there were some risks identified by inspectors which were not included on the register such as the use of manual key locks on evacuation doors and the holding open of fire doors with furniture.

Risk assessments relating to individual residents were contained in each resident's personal plan. While reviewing a log of accidents and incidents that occurred in the centre inspectors read a number of reports involving falls for a resident within their home. On review of the resident's personal plan it was noted that this resident was identified as being at a high risk of falls. There was evidence that the provider had taken some steps to mitigate this risk, for example hand rails had been installed in the halls of the resident's home and in their bathroom.

However, it was noted that some of the resident's falls were taking place in their bedroom going back to May 2017. Padding had been inserted in the resident's bedroom to reduce the risk of injury but after the resident suffered another fall in their bedroom the week before this inspection, which required medical treatment, additional padding was inserted into the resident's bedroom. The resident's bedroom was viewed by inspectors and it was noted that some of the padding put in place had fallen off with a

staff member saying that the padding "fell off sometimes".

It was confirmed by the person in charge that the resident's bedroom had yet to be reviewed by an Occupational Therapist (OT) although records were provided to inspectors which confirmed that a referral had been made in the month of this inspection. When reviewing this resident's personal plan it was also observed that a referral for a physiotherapist review was made in March 2017 while a referral for an orthopaedic review had been made in June 2016. This resident was assessed and observed by inspectors to have balance issues but neither of these reviews had taken place at the time of this inspection. The need for OT, physiotherapy and orthopaedic reviews were not highlighted as additional control measures required in the relevant risk assessment.

Inspectors also reviewed another resident who was on a modified consistency diet as recommended by a speech and language therapist (SLT) to assist their eating and drink. The resident was risk assessed as being at a high risk of choking. Inspectors saw an incident report from July 2017 where the resident suffered a choking episode while eating necessitating the Heimlich manoeuvre to be used. While the resident was reviewed by a doctor following the incident, the resident had not been reviewed by SLT since the event nor had a referral been made. As such inspectors were not satisfied that a proactive approach to managing risk was always being followed within the centre.

Policies and procedures were in place with regard to infection control. Hand gels were available throughout the designated centre and staff had undergone training in hand hygiene. Cleaning was observed to be carried out on both days of the inspection.

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

Findings:
The provider had systems in place to residents were protected and kept safe. At the previous inspection, an action had been given in relation to how staff responded to

some behaviour. This action had since been implemented.

The provider maintained policies on the safeguarding of vulnerable adults and a separate policy on responding to behaviours. The organisation had introduced in 2017 an updated policy on the rights of residents and this addressed the use of restrictive practices.

Each resident had an assessment of their ability to self-care and arising from this, an intimate care plan was then created.

Inspectors reviewed training records and noted that all staff had been provided with training in safeguarding and de-escalation and intervention. However, some staff members were overdue refresher training in these areas. This is addressed under Outcome 17. During interview, staff confirmed their knowledge of safeguarding matters and the correct procedure should they have a safeguarding concern about a resident.

The person in charge informed inspectors that in the 12 months prior to this inspection there had been no allegations of abuse made. However, as discussed in Outcome one, the person in charge was asked by the inspector to review a number of complaints made by residents in relation to peer-to-peer incidents. These were reviewed by the designated officer in conjunction with the person in charge during the inspection and safeguarding plans were developed and risk assessments were updated.

Part of the multidisciplinary team available to residents included access to a behavioural support team. This discipline was also represented at the annual multidisciplinary review meeting of the resident. At the time of this inspection, there was evidence that residents had an individualised behavioural support plan in place or that they were being assessed for same. An inspector noted that a resident had two behavioural support plans on file which may be confusing for staff to follow. This was addressed during the inspection and one of the plans archived.

There was some use of restrictive practices at the centre. The use of same was governed by a newly revised policy that at the time of this inspection was being rolled out across the organisation. Practices consisted of the use of bed rails and bumpers, devices such as helmets, the locking of exit doors (released through fob systems) and some locking of kitchen doors at different times of the day. The person in charge was seeking at the time of this inspection, further guidance from the manufacturer regarding the use of devices, such as helmets, which was in line with organisational policy. The person in charge was also reviewing the practice of the locking of kitchen doors. The person in charge committed to reviewing the necessity of this practice in order to ensure that all methods had been exhausted prior to the continued use.

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:
All incidents requiring notification to HIQA had been submitted within the required timeframe.

A system was in place in the centre for recording accidents and incidents. A log of such events was reviewed during the course of the inspection and it was found that all notifiable events had been submitted within the timeframes set out by the regulations.

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:
Residents were supported to access education and training, however, the evidence of residents' capabilities in this area was not assessed.

All residents living at this centre had available to them a day service located within walking distance. The inspectors observed some of the residents attending this service. It was clear that the residents enjoyed visiting the day service and visiting the management team whose office was based in this building. There was plenty of laughter and discussion observed between the residents and the management team. Other residents chose to attend a service that was not on-site and they were facilitated and supported to attend this service by staff.

The annual review of the centre conducted prior to this inspection found that learning goals assigned to residents did not always reflect their cognitive ability. The cognitive ability of each resident had not been assessed nor had the ability of each resident to be

employed or to volunteer. This was especially significant for those residents who chose not to utilise the day service. There was a section on education in each resident's file and staff were required to record goals in this area. However, the goals assigned to residents were generally activity-based goals more so than educational goals.

The personal planning arrangements for each resident were reviewed by a multidisciplinary team of professionals, employed by the organisation. This was an annual event. The inspector observed that that the multidisciplinary review meeting discussed the physical and social activities requirements of each resident. However, it was not explicit how this review addressed the cognitive and learning ability of each resident and their subsequent ability to attend a day programme, volunteer or to be employed in the community. This issue was also cited in the annual review of the centre.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
There were systems in place to ensure that residents had their healthcare needs assessed and supported, however, better oversight of records was required.

Residents had access to general practitioners (GPs) through the organisation. They also had access to a multidisciplinary team and this included disciplines such as psychology, physiotherapy and occupational therapy. A consultant psychiatrist visited the campus on certain dates and could be accessed through an open clinic and by referral. The person in charge informed the inspectors that end of life care plans would be established, as per policy, when the need arose.

The review of the effectiveness of healthcare management plans in place for all residents was in its infancy due to the introduction of updated personal planning arrangements. This meant that healthcare goals were newly set and such progress notes regarding the achievement of goals in this area were not yet written. Where required, residents' files viewed had mental health plans devised for them. However, these were found to not always be dated or signed.

A protocol on file for staff to refer to in the event of a rescue medication being required

was more than two years old. This was brought to the attention of the person who committed to the reviewing of this immediately.

When reviewing one resident's personal plan it was noted that the resident had a dietary plan in place since July 2016 to increase their weight. These recommendations included both a recommended weight range and a specific weight target. To monitor the resident in this regard, they were to be weighed at fortnightly intervals and if a pattern of weight loss was observed on consecutive months then a dietitian was to be contacted. Inspectors were provided with records showing that the resident was being weighed on a fortnightly basis as recommended. However, while the resident's weight had generally remained steady since July 2016, they had not entered their recommended weight range or meet their specific weight target during this time. In addition it was noted that between May and July 2017 the resident's weight had dropped. However despite these the dietary plan in place had yet to be reviewed.

The needs of some of the residents were such that they required a high level of support from staff in their eating and drinking. Where required, each resident had their own individualised eating and drinking regime (as prescribed by a speech and language therapist). This information was displayed in each centre for all staff to see. During interviews, staff members could articulate the regimes of each resident. At this centre, the main meal of the day was served at lunch-time and prepared by a separate service of the organisation. Residents were offered a choice in their food. Staff prepared meals for the residents during the weekends and residents were also facilitated to go to restaurants and cafes in line with their peers.

Judgment:
Substantially 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, however some improvements were required.

The provider maintained a policy on medicines management.

Samples of prescription and administration records were reviewed by an inspector. It was found that the required information such as the medicines' name, the medicines'

dosage and the residents' dates 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. At the time of this inspection, there was no resident prescribed drugs that required stricter controls. A nurse, with whom an inspector spoke with was aware of the requirements for these drugs to be kept separate and in a secure area.

There were systems in place for the auditing of medicines management at the centre. An inspector viewed findings from audits completed in the 12 months prior to this inspection and the results were mostly positive with few findings. The management team were familiar with all findings and had appropriately acted regarding same.

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 not all care staff were trained in the administration of this medicine. This has been referenced in Outcome 17.

There was a system in place to ensure that residents were assessed in their capability to self-administer medicines. One resident informed an inspector that they were involved in some of their daily heath checks.

Judgment:
Compliant

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 lacking detail in relation to some of the requirements of the regulations. Before completion of this inspection, an amended statement of purpose was provided to inspectors which addressed these issues.

The statement set out the aims, objectives and ethos of the centre. It confirmed management and staffing arrangements and described the services and facilities to be provided. The statement had been reviewed within the previous 12 months and was available to residents and families.

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):
No actions were required from the previous inspection.

Findings:
There was a clear management structure at the centre; however, some of the findings from this inspection showed how improvements in the provider's oversight were required at a governance level.

The management system at the centre was clear. Care assistants reported to nursing staff who in turn reported to persons involved in the management of the centre. These persons then reported to the person in charge who in turn reported to the person representing the provider. During interview, staff were clear about who was in charge and of the management structure. On-call services were provided during out of hours. The representatives of the residents confirmed to the inspector that they enjoyed good relations with the staff team, including management.

There were audits completed within the centre and the wider organisation on aspects of the delivery of service. The inspectors viewed a sample of these audits and these were found to have been conducted by all levels of staff. It was not always clear that findings had a corresponding written action plan, although the management team could provide updates regarding same.

In the 12 months prior to this inspection two six monthly unannounced inspections had taken place.

There were systems in place for the completion of the annual review of the centre for 2017 and the person representing the provider was aware of the requirements of the regulations in this regard. The annual review of the centre encompassed observations of the residents and the viewpoints of family representatives. A family forum had also been organised by the person in charge for the representatives of families in 2017 during which their views of the service were ascertained. The person in charge could account for all findings arising from this review and set out progress against same. The findings

of this inspection of areas relevant to admissions, risk analysis and fire safety were indicative of better oversight required by the provider.

The centre was managed by a clinical nurse manager (the person in charge). At the time of this inspection, she was person in charge of this designated centre and a person involved in the day-to-day management of a second centre. She was supported in her role by three persons involved in the day-to-day management of this centre. The person in charge was committed to her own personal development, as evidenced by her continuing professional development. She was supernumerary to the roster.

The persons involved in the day-to-day management of the centre demonstrated a good knowledge of the Regulations, were aware of the responsibilities of their roles and were actively involved in the management of the centre. Both knew the residents and their families very well.

Judgment:
Substantially Compliant

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:
Inspectors noted that there were sufficient resources available to meet residents' assessed needs and to provide the service as outlined in the statement of purpose.

Resources available included en-suite facilities in all bedrooms, vehicles and a skill mix to support residents in accordance with their assessed needs.

Where residents were awaiting healthcare devices for some time and the acquiring of same was proving difficult through the public health system, the decision-making process to acquire individualised aids and appliances using a resident's personal finances was not clear.

Judgment:
Substantially Compliant

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

Theme:
Responsive Workforce

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

Findings:
Inspectors were satisfied that there were appropriate levels of staff to meet the needs of residents although the provision of training remained an area for improvement and there was no system of formal staff supervision in place.

Positive and warm interactions were observed between residents and staff members during this inspection. Having observed practice and spoken with residents, their relatives and staff members, inspectors were satisfied that there were appropriate numbers of staff to meet the needs of residents. A review of staff rosters indicated that staffing continuity was provided for while nursing staff was also in place.

In relation to staff training, the previous inspection found that staff had not received mandatory training including refresher training. At this inspection training records were

again reviewed and it was found that staff had received mandatory training. However it was noted that some staff were overdue refresher training in areas such as fire safety, manual, safeguarding, de-escalation and intervention. Inspectors were informed that staff members overdue refresher training were booked in to receive such training. It was also observed that there was a need for staff to be provided with training in mental health and autism to reflect the needs of residents living in the centre. Not all care staff were trained in the administration of rescue medication.

Staffing meetings took place at quarterly intervals where issues such as audits, training and safeguarding were discussed. However while a performance management system was in place within the centre, a process of formal staff supervision was not yet in place within the provider. This had been identified in the provider's own annual review carried out in August 2017 which highlighted that a policy in this area was required.

Inspectors reviewed a sample of staff files and found that the required information was contained in these files including evidence of Garda vetting, two written references and evidence of identity. Inspectors were informed that there were no volunteers involved with the centre at the time of 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):
No actions were required from the previous inspection.

Findings:
Records and policies were in place within the centre. There were some improvements identified regarding the directory of residents and the signing and dating of documents.

Inspectors viewed a copy of the directory of residents and this contained most of the relevant information, as per the regulations. However, the directory did not set out the dates that the residents did not reside at the centre during the previous 12 months. This had been identified prior to this inspection in the provider's annual review.

A revised resident's guide was submitted following the inspection and this met the requirements of the regulations.

All Schedule 5 policies and procedures, as required by the regulations, were in place, however, some were found to be outside of their three year review. The person representing the provider gave assurances that all policies whose date of review had passed were being reviewed at the time of the inspection by personnel within the organisation.

Some records required dates and signatures such as health management plans. Findings from audits did not always have an attached action plan.

The centre was adequately insured.

Judgment:
Substantially Compliant

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:

Carol Maricle
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[1]

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0005395
Date of Inspection:	30 and 31 August 2017
Date of response:	13 November 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 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:
The quality, quantity and location of tableware for a resident was not suitable.

1. 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

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

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:
Resident now has a designated press for their own tableware and belongings. New items have been sourced for the resident. These new items have been sourced and are still within the residents SALT guidelines.

Proposed Timescale: 13/11/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An audit of meal times had identified a need for visuals at the centre at the weekend regarding meal choices.

2. Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
The PIC will ensure that all houses in the designated centre have a visual board that shows residents food options available at weekends.

Proposed Timescale: 30/11/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The internet facilities were not easily available to all, as evidenced by a resident awaiting these facilities at the time of the inspection.

3. Action Required:
Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

Please state the actions you have taken or are planning to take:
Internet access is available at dedicated sites within the designated centre.
A web cam will be provided for access to skype.

Proposed Timescale: 30/11/2017

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 annual review of the centre stated that the contracts of care for residents were not all up-to-date nor specific to the individual.

4. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
Contracts of care will be reviewed to ensure they are up to date and specific

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There had been two emergency admissions to the centre in the 12 months prior to this inspection and the management team stated that the admissions had not been in line with their own organisational policy. Family representatives stated that they did not receive adequate notice of same.

5. Action Required:
Under Regulation 24 (2) you are required to: Provide each prospective resident and his or her family or representative with an opportunity to visit the designated centre, insofar as is reasonably practicable, before admission of the prospective resident to the designated centre.

Please state the actions you have taken or are planning to take:
All future admissions will be in line with the organisations policy on admissions, transfer or discharge and a transition plan will be put in place for all planned admissions.

Proposed Timescale: 13/11/2017

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 documenting of achievements in goal setting was not always performed in a consistent way throughout the resident's files.

6. 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:
Documentation has been reviewed and a clear pathway on goal setting and achievement is now in place.

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:
The provider's own annual review had identified the need for a new medication fridge in one unit.
The suitability of the location of one medication press in the kitchen of one unit had not been reassessed.

7. 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:
New Medication Fridge is now in place. Quotation received and new medication storage units will be sourced

Proposed Timescale: 31/12/2017

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:
As detailed in the inspection findings, a proactive approach to risk was not always evident. Some risk assessments required review to ensure that they adequately reflected the actual level of risk within the centre. Some risks identified by inspectors were not included on the register.

8. 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:
A review of risk register will take place to ensure all risks are relevant and appropriate

Proposed Timescale: 30/11/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Four fire doors were observed to be held open with furniture which would negate the effectiveness of the doors to contain a fire.

9. 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:
All staff in designated centre are aware that furniture is not to be used to hold a fire door open. All staff have documented that they have read and understand the fire prevention policy.

Proposed Timescale: 13/11/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident's PEP did not make reference to a specific evacuation technique to be used at night.

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

Please state the actions you have taken or are planning to take:
This residents PEP has been reviewed and specific evacuation technique has been included.

Proposed Timescale: 13/11/2017

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:
It was not demonstrated that environmental restrictive practices such as the locking of an internal door were only used following the exhaustion of all other methods.

11. 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:
Where restrictive practices are in place a clear detailed rationale as to their use will be displayed in the person's personal plan. The decision making process will be clearly identifiable and will be in accordance with the regulations

Proposed Timescale: 30/11/2017

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:
The capabilities of residents with regard to their education and learning had not been assessed.

12. 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:
Residents will be supported to access opportunities for education, training and development. A review of goal setting will take place to ensure a holistic approach is taken when identifying goals. The annual multi-disciplinary meeting will address Education & Learning for each resident.

Proposed Timescale: 31/01/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that the recommendations in a dietary plan for one resident were being followed or that the plan was achieving its aim. A protocol for the administration of a rescue medicine required review.

13. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
The dietary plan was reviewed by the dietician and the residents target weight was adjusted appropriately, clear guidelines were given to staff regarding the resident's dietary intake and staff informed that monthly weights were to be obtained.
The protocol for medication administration was updated appropriately

Proposed Timescale: 13/11/2017

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 findings identified in this inspection in the area of admissions, fire safety and analysis of risk were indicative of a requirement for better oversight by the provider.

14. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The provider shall provide oversight with particular emphasis on admissions, fire safety and risk. The provider Nominee regularly meets with the PIC and matter that require escalation are dealt with through this forum.

Proposed Timescale: 13/11/2017

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where residents were awaiting healthcare devices for some time and the acquiring of

same was proving difficult through the public health system, the decision making process to acquire individualised aids and appliances using a resident's personal finances was not clear.

15. 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 clear decision making process in the use of personal finances will be developed.

Proposed Timescale: 31/12/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff were overdue refresher training in areas such as fire safety, manual, safeguarding, de-escalation and intervention. There was a need for staff to be provided with training in mental health and autism to reflect the needs of residents living in the centre. Not all care staff were trained in the administration of rescue medication.

16. 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:
A Training plan has been put in place to address both mandatory and non-mandatory training

Proposed Timescale: 31/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A formal system of staff supervision was not in place.

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

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

The organisation is currently developing a supervision policy which will be rolled out to all staff.

Proposed Timescale: 31/12/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not contain the details of the dates that each resident did not reside at the centre.

18. 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 dates that the residents do not reside at the centre are now being recorded in the directory of residence.

Proposed Timescale: 13/11/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some records of care provided to the resident were not signed or dated. Some audits completed did not always have an action plan attached.

19. 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:
All records of care will be signed and dated. All audits will have an action plan attached.

Proposed Timescale: 30/11/2017