



# Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Cork City North 7
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	09 March 2018
Centre ID:	OSV-0003297
Fieldwork ID:	MON-0021222

## About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The Cope Foundation had produced a document called the statement of purpose, as required by regulation, which described the service provided. The statement of purpose identified that the centre was a 32 bed residential centre setting consisting of four houses on a campus setting in the community. Each of the houses was a two-storey house with the same overall layout including a kitchen, separate dining room, living room and conservatory room. The stated aim and objective of the centre "was to promote a welcoming and homelike environment ensuring always that residents' dignity and safety was promoted".

**The following information outlines some additional data on this centre.**

Current registration end date:	06/07/2017
Number of residents on the date of inspection:	32

## How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

### **1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

### **2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
09 March 2018	11:00hrs to 18:30hrs	Kieran Murphy	Lead

## Views of people who use the service

The inspector met with approximately 16 of the residents living in the centre. The inspector also met with staff and without exception, all interactions between staff and residents was respectful.

On the day of inspection residents were at home, at work or in a day service that was also located on the campus.

There were eight people living in each of the four houses with a wide range of ages and some residents with increasing needs for health care support.

Residents spoken with said they were happy living in the centre with lots of things to do. It was noted that more individualised one-to-one social development programme for residents had been developed. It was planned that residents would go on holidays to the seaside in May this year and one resident said that they had never been on holidays before and was really looking forward to the break.

## Capacity and capability

This was a focused inspection and was primarily concerned with residents' quality of life, changing health care needs for residents and the governance arrangements in the centre. Overall in relation to Capacity and Capability it was found that the governance structures provided a good oversight of the quality and safety of care being provided in the centre. In addition, the service had showed itself to be responsive to the changing needs of residents and had ensured there was sufficient staff with the right skills, qualifications and experience to support residents.

Previously this centre had been part of a larger designated centre based on a campus setting on the north side of Cork city. This inspection was scheduled following an application by Cope Foundation to register the current re-configured centre. This was the first inspection of this centre by the Health Information and Quality Authority (HIQA).

In November 2017 a new person in charge had been appointed to the centre. The person in charge had professional qualifications in social care and a number of years experience of supporting people with an intellectual disability. The governance arrangements for this centre included oversight by a regional manager who was a qualified nurse in intellectual disability. At an operational level the person in charge was supported by two senior nurse managers, an experienced staff team staff

nurses, team leaders and social care workers.

The COPE Foundation had ensured that an annual report in relation to the quality and safety of care in the centre had been completed in November 2017. There was a prepared written report available in relation to the “themes” that had been reviewed including: individualised supports and care, effective services, safe services, health care, leadership, use of resources, workforce and information. This review had an action plan to address any deficiencies identified. It was noted on inspection that there had been substantial improvement in areas identified in the annual review including increasing supporting residents with communication and in activities for residents. However, not all of the deficiencies had been adequately addressed including issues relating to person-centred care planning.

As an example of good practice, the person in charge had introduced a safety and risk committee for the centre with a specific remit of ensuring the quality and safety of the service. The records of the most recent meeting included review of issues like incidents, staff training, clinical issues and infection control. The centre also had a schedule of audits, either completed or planned. The audits seen by the inspector included reviews of documentation, medicines and personal planning.

A copy of the staff rota was available in a picture format in all four houses so that residents were aware of which staff were on duty. It was noted that there had been an increase in staffing in one of the four houses, which meant that there was more time for residents to engage in activities. There had also been a restructuring of staffing in the day service so that individualised supports could be provided to one particular resident.

Each of the four houses had a staff member, called the house leader, who coordinated the supports being provided to residents. Staff said that this ensured that there was consistency in the supports for residents. It was noted that there was one full-time “awake” staff at night, with support available from a nurse and a senior nurse manager from another centre on the campus.

There were regular house meetings and in the records for the most recent meeting in one of the houses issues discussed included communication supports, standards of care and restrictive practices.

## Regulation 15: Staffing

There were appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services.

Judgment: Compliant

## Regulation 23: Governance and management

Effective management systems were in place that supported and promoted the delivery of safe, quality care services.

Judgment: Compliant

## Quality and safety

Overall in relation to Quality and Safety it was found that a priority for the service had been to support residents to engage in meaningful activities during their day and it was observed that this had commenced with the potential to greatly improve the quality of life for residents in this centre. However, the centre was not meeting the needs of all residents and the service acknowledged that one resident's needs in particular were not being met. In addition, improvement was required in relation to person-centred planning and the review of restrictions in some residents' lives.

There was evidence that one resident who had been recently admitted on an emergency basis was inappropriately placed. The COPE Foundation and the resident had engaged in a comprehensive process to identify a more suitable placement and this process was ongoing.

On this inspection it was noteworthy that the service had introduced more social, educational and community integration opportunities for residents, and particularly was providing a more individualised one-to-one social development programme for residents. This was in addition to some residents attending a day service on site. Two Activities Coordinators had been appointed to the service in recent months and both were enthusiastic about their role and had worked with residents to develop individual community inclusion activities. New activities that residents engaged in included horse riding and some residents attended an autism friendly activity club in the local secondary school. There had also been an increase in activities for residents during the evening including a club social night and the centre had adopted a donkey from a local donkey sanctuary.

One area of excellence in this service was that all residents in one of the houses had received support from a speech and language therapist in the development of individualised communication strategies. This was a video feedback communication project which was an interaction programme that provided concrete and practical information to carers on supporting the social, emotional and communication development of individuals. From this video project each resident had recommendations in place to increase opportunities for the resident to

communicate. The overall aim of this pilot project was to develop a total communication environment in the centre.

In relation to health care needs; each resident had "health care management plans" for all relevant health care needs. There was evidence that these health care plans were taking into account changes in circumstances and new developments. For example, if there were changing needs in relation to dementia there was comprehensive multidisciplinary support available for residents which provided detailed instructions for staff on how to appropriately support the resident.

Each resident had access to a general practitioner (GP) and there was evidence in the health care records that the GP was asked to review residents' health needs as required. There was excellent coordination of residents' health care needs between the residents' consultant specialist and the GP including access to specialist care from the psychiatry team led by the consultant psychiatrist.

In relation to the social care needs of residents, there were person-centred plans available for each resident in relation to community relationships and social inclusion. The residential personal plans also had the annual person-centred planning meeting. This planning meeting, with the resident at the core of the process developed community inclusion and lifestyle goals for the year. The goals identified the supports the person needed to achieve these goals and a time frame identified to achieve these goals. It was noted that not all residents had a completed person-centred plan but that there was a schedule to complete these.

There were three significant incidents submitted to the Chief Inspector since July 2017. Documentation in relation to these incidents was reviewed during the inspection and all safeguarding policies and procedures were being implemented.

It was observed by the inspector that in the last year a number of restrictions had been removed in the houses including the removal of locks on personal wardrobes. The person in charge outlined that an audit of restrictions had been completed by a behaviour therapist but this report was not available on the date of inspection. However, restrictions identified in the centre were not the subject of regular review.

## Regulation 10: Communication

Residents were supported to communicate at all times. Effective and supportive interventions were provided to residents where required to ensure their communication needs were being met.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents' opportunities for new experiences, social participation and work were facilitated and supported.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

The centre was not meeting the needs of all residents and the service acknowledged that one resident's needs in particular were not being met. In addition, improvement was required in relation to person-centred planning.

Judgment: Not compliant

### Regulation 6: Health care

Residents were supported on an individual basis to achieve and enjoy the best possible health.

Judgment: Compliant

### Regulation 7: Positive behavioural support

A restraint-free environment was promoted. However, the restrictions identified in the centre were not the subject of oversight or review.

Judgment: Not compliant

### Regulation 8: Protection

Measures to protect residents being harmed or suffering abuse were in place and appropriate action was taken in response to allegations, disclosures or suspected abuse.

Judgment: Compliant



## Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

# Compliance Plan for Cork City North 7 OSV-0003297

Inspection ID: MON-0021222

Date of inspection: 09/03/2018

## Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

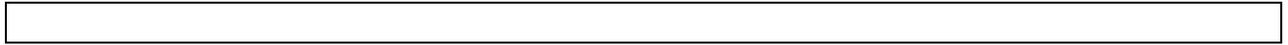
- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>All personal plans in the centre are being reviewed by the PIC to ensure that a comprehensive assessment has been carried out.</p> <p>A schedule plan has been developed for completion of personal plans . The process will be overseen by the Person in Charge . All plans will have been completed by the 31/10/2018.</p> <p>In relation to the one personal plan that was not reflecting the needs of one resident ,this is currently being developed and will be complete by the 10<sup>th</sup> July 2018.</p> <p>All personal plans will be subject to annual review or more frequently if there is a change in circumstances.</p>	
Regulation 7: Positive behavioural support	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <p>An audit of restrictions will be carried out by an external reviewer . This has been scheduled to be completed by the 31/7/2018. The Rights Restriction Committee of the Organisation will ensure regular review of restrictions to ensure that any restrictive practices are applied in accordance with policy and evidence based practice .</p>	



## Section 2:

### Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	10/7/2018
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31.10.2018
Regulation 07(4)	The registered provider shall ensure that, where	Not Compliant	Orange	31/7/2018.

	restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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