

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	North County Cork 5
Centre ID:	OSV-0003298
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Lead inspector:	Carol Maricle
Support inspector(s):	Conor Dennehy
Type of inspection	Announced
Number of residents on the date of inspection:	10
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 renewal 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:
24 January 2018 10:15	24 January 2018 18:00
25 January 2018 09:40	25 January 2018 10:30

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

How we gathered our evidence:

As part of the inspection, the inspectors met and spent time with nine residents and spoke to one family representative. The inspectors also received written feedback from a second family representative. Not all of the residents could converse with the

inspectors, therefore the inspectors observed staff interactions with the residents. The inspectors also met a number of staff including nurses and care assistants, the person in charge and the person representing the provider. The inspector read documentation such as a sample of residents' personal plans along with other relevant records kept in the centre. The inspector reviewed the policies and procedures in the centre and examined documentation which covered issues such as staff training, complaints and advocacy, personal plans, staff training and health and safety risk management.

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. The maximum number of residents that the centre could cater for was 10 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 one house that was spacious and well maintained. The centre was located on a quiet road, a short distance from the local town. The furniture and the fittings were found to be of good quality and the premises was suitable for the needs of the residents.

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:

- access to day services in the community (Outcome 3)
- aspects of residents' assessment of need (Outcome 5)
- drills, emergency plans and containment (Outcome 7)
- restrictive practices (Outcome 8)
- notifications (Outcome 9)
- self-capacity to administer medicines (Outcome 12)
- aspects of management (Outcome 14)
- staff supervision and training (Outcome 17)
- policies, records and the residents' guide (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:

There were systems in place to ensure that the rights, dignity of residents were respected. Residents were consulted with. The action from the previous inspection was implemented.

There were advocacy systems in place at the centre and residents were consulted with. There was information on advocacy available to all residents and monthly forums in place during which residents had opportunities to have their say in the running of their home. An inspector reviewed a sample of minutes from these forums and could see that there had been changes following suggestions made by residents.

There was a complaints system in place. Staff had confirmed in writing that they had read the complaints policy. An inspector viewed complaints received in 2017 and 2018 and could see that all of the complaints made had been resolved. The person in charge was aware of a particular complaint received regarding social outings and demonstrated to the inspector how the current staff ratio now offered more opportunities for residents to leave the centre and go out into the community than previously before.

Residents were supported to manage their finances and records of any transactions were kept within the designated along with corresponding receipts. A sample of such records was reviewed by inspectors and it was noted that receipts and transactions were appropriately signed for while balances recorded matched up. Arrangements were also in place for resident finances to be monitored.

There were four shared bedrooms at the centre. Privacy screens were provided for in

these shared bedrooms. At the time of this inspection, neither the residents nor their family representatives had raised concerns regarding the sharing of the rooms. The person in charge was cognisant of possible issues that may arise in the future as a result of the residents sharing bedrooms.

Judgment:

Compliant

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There were systems in place to ensure that residents were supported to communicate at all times.

The inspectors found that residents were supported by staff to communicate. The person in charge and staff team demonstrated a good awareness of the individual communication styles of each resident. The organisation had a speech and language service, to which staff could refer residents to. An inspector viewed a sample of residents' files and found that communication profiles were in place. Formal communication passports were not on file for all residents, however where this was the case, a referral had been submitted to the speech and language service of the organisation for the development of same.

The centre was part of the local community and residents had access to television, radio and newspapers. Residents were supported to attend local events.

Judgment:

Compliant

Outcome 03: Family and personal relationships and links with the community

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

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Residents were supported in developing and maintaining family and personal relationships and links with the community.

There was evidence to show that residents were supported to maintain relationships with their friends and family. This was confirmed by family members with whom the inspectors spoke with. There was a policy on visiting maintained by the organisation. At the time of this inspection, person-centred plans had been scheduled and as part of this process, family members had been or were in the process of being invited to these meetings to support their family member and also give their views.

Residents told inspectors how they liked to attend events that took place in the community. Family members confirmed these arrangements. The opportunities available to residents to leave the centre on Saturdays required ongoing review and this has been referenced further in Outcome seven.

During the inspection it was not found that there was a clear rationale as to why some residents attended day services located within the community and others attended the on-site day service run by staff employed at the centre. Following the inspection, the person in charge confirmed to the inspectors that a meeting had been arranged by her with the community-based day service in order that the assessment of the suitability of all residents to attend this community based service would commence.

Judgment:

Substantially 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):

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

Findings:

There were systems in place to ensure that admissions took place in a planned manner and residents had contracts in place for the provision of services. The action from the previous inspection had been addressed.

There was a policy on admissions maintained by the organisation and this described the admission process including assessment, access and the transition period that would be agreed with the resident. The person in charge was aware of the policies in this area. At the time of this inspection, none of the residents were in the process of discharging themselves from the centre.

The inspector reviewed a sample of personal planning arrangements for those living at the centre and found each had an agreed and signed contract in place. The contracts included details of the services to be provided and there was additional information for the resident on fees to be charged for services provided.

Judgment:

Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

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.

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, positive behavioural support and mobility requirements. These assessments were generally conducted by a member of the nursing staff. Where an individual has a diagnosis of autism, the inspector found that the impact of this diagnosis on the day-to-day life of the resident was not found on file, therefore the personal planning around this diagnosis was not clear.

Each resident, whose file was viewed by the inspector, had a person-centred plan which was a document all about them, their likes and dislikes and goals that they would like to achieve or were scheduled to attend this meeting and give their views on same. Where

a resident did not have this plan in place, a meeting to formulate this plan was scheduled.

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. A key worker system was in place at the centre and the key workers generally took responsibility for updating personal plans.

There were systems in place regarding goal setting to demonstrate 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. At the time of this inspection these systems had been newly introduced at the centre meaning that the goals were newly set and therefore there was not yet a formal documentation of progress against 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 person in charge demonstrated appropriate awareness of the outcome of these meetings and could articulate the progress of all recommendations that arose from 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 suitable to meet the needs of the residents living in this designated centre.

The designated centre was a purpose-built detached bungalow, located outside a town and was within a short driving distance to local shops and amenities. Within the centre there were six bedrooms, two of which were individual bedrooms and four double bedrooms, which provided a home to 10 residents. The centre also had a large sitting

room, a kitchen, dining area, two bathrooms, a shower room, a utility room, store rooms and a staff office. All rooms within the centre were observed to be well furnished.

Efforts had been made to give the centre a homely feel, for example various artworks and photographs of residents were on display throughout the designated centre. Inspectors saw some residents' bedrooms which were observed to be colourfully decorated and personalised. Residents were provided with ample storage through large wardrobes in the bedrooms.

The designated centre was surrounded by a well maintained large garden area with a patio area. The designated centre was presented in a clean manner on the day of inspection and was generally observed to be in a good state of repair.

Judgment:

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:

Inspectors were satisfied that appropriate efforts were being made to promote the health and safety of residents, staff and visitors in the designated centre; however the procedures for night-time evacuations required further review.

The previous inspection had found that all hazards in the centre had not been identified, risk assessed or controls put in place in accordance with the risk management policy for the centre. During this inspection it was found that a comprehensive risk register was in place which had been reviewed during the month of this inspection. However it was noted that weekend staffing levels had not been adequately risk assessed. Inspectors received confirmation that this had been assessed following completion of the inspection and the issue escalated to the person representing the provider. There was no risk assessment contained in the file of a resident of a hazard pertaining to weight management.

Appropriate policies relating to health and safety and risk management were in place while audits in areas such as cleaning were also conducted. Training records indicated that all staff had received training in manual handling but some were overdue refresher training in this area. A process for recording accidents and incidents occurring in the centre was in place. Inspectors were told that learning from any adverse events was shared with staff through regular staff meetings. An emergency plan was also in place

but did not adequately address where all residents were to be accompanied overnight if an evacuation of the centre was required.

A fire alarm system, emergency lighting, fire doors and fire fighting equipment including fire extinguishers were present in the centre. Emergency lighting was seen to be operational on the day of inspection while fire exits were also observed to be unobstructed. The fire evacuation procedures were also on display throughout the centre. However it was noted that the fire door to the staff office was not closing fully at the time of inspection which could reduce its effectiveness in the event of a fire. The fire assembly point was not fully accessible on the day of the inspection due to the location of vehicles and this was addressed immediately following the inspection.

Internal staff fire safety checks were being carried out and documented. Inspectors saw records of certificates of maintenance carried out by external bodies for the fire alarm, emergency lighting and the fire extinguishers. Training records reviewed also indicated that all staff members had received fire safety training but some were overdue refresher training in this area. The person in charge informed inspectors that such training had been scheduled.

Residents had personal evacuation plans (PEPs) in place and fire drills were being carried out at regularly intervals at varying times of the day. Records were maintained of these drills which included the names of staff and number of residents who took part along with the duration of the evacuation. Any issues arising in drills were documented with residents' PEPs. Staff spoken to indicated that they had participated in recent fire drills.

However, when reviewing the evacuation times of fire drills carried out during night-time, inspectors observed considerable variance between the times listed for evacuations to take place. For example some night-time drills had been completed in less than 2 minutes but in September 2017 one drill had taken 6 minutes while a fire drill carried out the week before this inspections had taken over 9 minutes.

In response to latter evacuation time two further night-time fire drills had taken place before this inspection where the evacuation times had reduced and additional measures introduced. However given the variance in evacuation times recorded over the previous 12 months, further review of the evacuation procedures at night-time was required to ensure that all residents could be consistently evacuated in a reasonable time having regard to the changing needs of residents and the levels of staff provided at night-time.

Inspectors reviewed the vehicle that the designated centre had access to. It was noted to be insured and appeared roadworthy with appropriate maintenance checks having been carried out. Hand gels and personal protective equipment were available throughout the designed centre.

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):

No actions were required from the previous inspection.

Findings:

The provider had systems in place to ensure that residents were protected and kept safe.

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. Inspectors reviewed training records and noted that all staff had been provided with training in safeguarding and responding to behaviours that require a response

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

The person in charge informed inspectors that in the 12 months prior to this inspection there had been a number of alleged verbal abusive interactions between some residents that had not been reported to her in accordance with organisational policy. She confirmed in writing to HIQA following the inspection that all such incidents had now been reviewed by her and the designated officer and that safeguarding plans developed for all concerned. This issue has also been referenced in Outcome 9.

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. An inspector noted that there was not always a clear correlation between a resident's behavioural support plan and the protocol for administering a medicine "when required" (PRN). The rationale for the administration of a PRN was not always documented by staff. The effectiveness of the PRN medicine was not always documented. This has been commented upon in Outcome 18.

Overall, there was minimal use of environmental restrictive practices in place at the centre. At the time of the inspection some of the windows in room had restrictors and

there was the locking away of dangerous chemicals. There was some use of bed-rails however the use of same was technically not following organisational policy as this policy requires staff to risk assess both the use and non-use of this intervention.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

A system was in place within the centre for recording accidents and incidents.

A log of such events was reviewed during the course of the inspection. Prior to the inspection the inspectors were informed that it had been identified by the person in charge that there had been a number of safeguarding incidents between residents which had not been notified to HIQA as required. In addition, in the previous year (2017) not all administrations of medicines taken "when required" (PRN) had been recorded in the quarterlies submitted to HIQA.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Residents were supported to access education and training.

Some residents living at this centre had available to them a day service located within driving distance. Others had a day service located on the same campus at the centre. This was situated within walking distance of this centre. The inspectors observed some of the residents attending this service and it was clear that the residents enjoyed visiting either day service they attended. However, there was no clear rationale why some residents attended the community-based day services and others did not. This has been commented upon in Outcome 3.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There were systems in place to support the healthcare of all residents. The person in charge demonstrated a comprehensive oversight of the health needs of the residents and was aware of their changing needs as they approached retirement age.

Residents had access to general practitioner (GP) services and other services, such as dentistry, psychology, occupational therapy, social work and speech and language. There was evidence in personal plans that residents had availed of these allied health care services. Residents, where necessary, were being screened for dementia and falls. Each resident had been discussed by the multidisciplinary team prior to this inspection and any recommendations were being progressed by the person in charge and her team.

There were new healthcare management plans being introduced for all residents. These healthcare plans addressed issues that arose at the assessment of the needs of the residents. As this was a new system recently introduced evidence of the effectiveness of these healthcare plans was yet to be charted. The mental health plans created by the staffing team required sign off by a professional qualified in this area. Hospital passports were in place. The inspectors observed that there were gaps in aspects of record keeping, for example, there was inconsistency in the frequency of recorded nursing care notes about residents and their day-to-day experience while in the care of the centre. This has been commented upon in Outcome 18.

The needs of some of the residents were such that they required a wide range of 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). Staff were aware of residents' dietary needs regarding texturizing of food. The organisation maintained a policy on nutrition and hydration. Each resident's person-centred planning folder contained details of residents' particular food likes and dislikes. Residents had their main meal either in the training centre or in their home. Staff prepared meals for the residents and residents were also facilitated to go to restaurants and cafes in line with their preferences. The inspectors found adequate quantities of food available for snacks and refreshments.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Procedures were in place relating to medicines management, however improvements were required in the assessment of the residents for their suitability to self-administer medicines. The actions arising from the previous inspection had been implemented.

The provider maintained a policy on medicines management. There were local protocols in place that helped staff to understand the medicines management processes in the centre. Medicines were dispensed from the pharmacy in a monitored dosage system. They were kept securely in a locked area. The location of all medicines was moved to a more suitable location during the inspection. This move had been planned prior to this inspection. At the time of this inspection, there was no resident prescribed drugs that required stricter controls. An auditing system was in place regarding medicines management with a clear schedule for the coming year. At the time of this inspection residents were not assessed in a formal capacity of their ability to self-administer medicines.

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 administration sheets viewed by the inspector matched the information contained in the prescription charts.

Judgment:

Substantially 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:

The statement of purpose was amended during the inspection to ensure that it contained all of the required information.

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.

The management system at the centre was clear. Care assistants reported to nursing

staff who in turn reported to the person in charge. During discussions, staff were clear about who was in charge and the management structure. On-call services were provided during out of hours. The residents confirmed to the inspectors that they enjoyed good relations with the staff team and knew who was in charge.

An audit schedule was in place and a number of audits were carried out each year on different areas such as infection control, fire safety, medicines management, hand hygiene and intimate care. The results of these audits were shared with the staff team.

An inspector viewed a sample of staff team meeting minutes and found that a wide range of information relevant to the residents and the running of the centre was discussed such as risk assessments, behaviour support, seasonal events, healthcare issues and incident reporting.

There were systems in place for the completion of the annual review of the centre for 2017 and the representative of the provider was aware of the requirements of the Regulations in this regard. The person in charge could account for all findings arising from this review and set out progress against same. The annual review cited an urgent need for a post-holder to assist the person in charge to discharge her duties. There had been two six-monthly unannounced inspections of this centre in 2017, the findings of which the person in charge demonstrated awareness of and progression of all actions. However, these inspections failed to identify the significant lack of reporting of peer-to-peer safeguarding concerns in the 12 months prior to this inspection.

The person in charge was employed full-time and was found to have the qualifications, skills and experience necessary to manage the centre. She was also appointed as person in charge for one other centre located across a broad geographical area. 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 annual review of the centre identified that she was not supported in her role by a deputy. The representative of the provider stated to the inspectors at the feedback meeting that they were hoping to appoint a person who would support the person in charge to discharge her duties. This would therefore give the person in charge additional whole-time equivalent in her governance of this centre and a second centre. This plan was not yet formalised at the time of conclusion of this inspection.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The provider was aware of their responsibility to notify HIQA of the absence of the person in charge where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or 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):

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

Findings:

The centre was adequately resourced to ensure aspects of the effective delivery of care and support in accordance with the statement of purpose however these resources required on-going review to ensure that the needs of residents were met.

There was a suitable mix of care staff and nursing staff available to assist residents. Residents had choice in relation to activities. The centre was maintained to a good standard inside and out and had a fully equipped kitchens and laundry facilities across all of the units.

The availability of staff on a particular day of the week has been referenced under Outcome 7.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

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

Findings:

During the inspection positive and warm interactions were observed between residents and staff members.

At the time of this inspection, inspectors were satisfied that there were appropriate levels of staff in place to meet the needs of residents. However, in the weeks before this inspection it was noted that the staff shortages had been risk assessed by the person in charge. This risk had been escalated to the provider representative and as a result a domestic staff member had been allocated to the centre which freed up the existing staff compliment to address residents' needs. It was outlined to inspectors that it was intended that this domestic staff post would remain in place following this inspection. The level of staffing on Saturdays required a risk assessment to ensure that residents could be facilitated to leave the centre on a Saturday and this has been commented upon in Outcome 7.

At the time of the inspection a full-time activities co-ordinator post-holder was on long term leave but expected back shortly following the inspection. Prior to this inspection, a staff member focusing on activities had been appointed to the team for three days of the week. During the inspection, staff commented positively to inspectors on the benefit of this additional staff member and how it made a positive impact to the day-to-day life of the residents.

At the previous inspection it was found that all staff did not have access to updated mandatory and appropriate training. Training records reviewed at this inspection showed that staff had received such training in areas such as manual handling, de-escalation and intervention, safeguarding and fire safety. However records indicated that some staff were overdue refresher training. The person in charge informed inspectors that arrangements were in place for such staff to receive such refresher training.

A sample of staff files were reviewed and were noted to contain all of the required information such as proof of identity and evidence of Garda vetting. Inspectors also reviewed a volunteer file and found Garda vetting in place while the roles and responsibilities of the volunteer were also set out in writing. The person in charge outlined to inspectors the arrangements in place for supervising volunteers.

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 September 2017 which highlighted that a formal process of supervision was required.

Judgment:

Substantially Compliant

Outcome 18: Records and documentation

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

Theme:

Use of Information

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Records and policies were in place within the centre. However, some improvements were required.

A directory of residents maintained for the centre was made available to the inspector.

An inspector reviewed the resident guide and found that it did not contain the information set out by the Regulations as it did not make reference to how residents could access inspection reports on the centre, the arrangements for residents to be involved in the running of the centre and the terms and conditions of residency.

The inspector was provided with a copy of an insurance certificate which confirmed that there was up-to-date insurance cover.

During inspections of other designated centres under the auspices of the registered provider in 2017 it was found that a number of the required policies had not been reviewed for over 3 years as required by the Regulations. During the inspection of this centre, inspectors reviewed the policies that were in place in this centre and it was again observed that a number of the policies were dated 2014 and therefore had not been reviewed within the required timeframes.

During the course of this inspection, the inspectors viewed a wide range of records and found that there were gaps in aspects of record keeping, for example, there was inconsistency in the frequency of recorded nursing care notes about residents and their day-to-day experience while in the care of the centre.

The rationale for administering medicines as required was always not clearly documented.

The progression in the previous year of goals that the residents had wished to achieve

was not always documented, however the inspector was informed that this matter would be addressed in the revised templates being used going forward. The person in charge accepted that the regularity of record keeping required formalisation.

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 report¹

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003298
Date of Inspection:	24 & 25 January 2018
Date of response:	11 April 2018

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 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

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

There was no clear rationale as to why some residents attended day services located within the community and others attended the on-site day service run by staff employed at the centre.

1. Action Required:

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

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

The PIC has arranged a meeting with the manager of the day service and the on-site day service to discuss each resident and their access to the respective day services

Proposed Timescale: 30/04/2018

Outcome 05: Social Care Needs

Theme: Effective Services

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

Where an individual had a diagnosis of autism, the inspector found that the impact of this diagnosis on the day-to-day life of the resident was not found on file, therefore it was not clear the arrangements put in place regarding this diagnosis.

2. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

A health action plan for Autism has now been added to the individuals support plan.

Proposed Timescale: 11/04/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The emergency plan in place did not adequately address where all residents were to be accompanied overnight if an evacuation of the centre was required.

3. Action Required:

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

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

The PIC has made arrangements with a local hotel in the community and all residents will be accommodated there overnight in the event of an emergency.

Proposed Timescale: 11/04/2018

Theme: Effective Services

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

The fire door to the staff office was not closing fully at the time of inspection which could reduce its effectiveness in the event of a fire.

4. 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:

The Fire door has been fixed and is now closing fully.

Proposed Timescale: 11/04/2018

Theme: Effective Services

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

The procedures for evacuating residents at night in the event of a fire required review in light of considerable variance in the recorded evacuations times for the 12 months before this inspection.

5. 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:

The PIC has ensured that any individual that has been identified as having difficulty with an evacuation now has a fire evacuation blanket in place. This process has been tested and is proven to be effective in evacuating all residents within the appropriate timeframe.

Proposed Timescale: 11/04/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There was not always a clear correlation between a resident's behavioural support plan and the protocol for administering a PRN medicine. There was some use of bed-rails

however the use of same was technically not following organisational policy as this policy requires staff to risk assess both the use and non-use of this intervention.

6. Action Required:

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

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

The PIC met with all staff and it has been agreed that staff will clearly identify and document clearly in the notes the point on the PRN protocol that the PRN medication was given.

The PIC has completed a risk assessment for the use and non-use of bedrails to ensure that the Organisational policy is being followed.

Proposed Timescale: 11/04/2018

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Not all details of medicines taken as PRN had been recorded in the quarterlies submitted to HIQA in the year prior to this inspection.

7. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

The PIC has reviewed this process and the PIC will ensure that all PRN's given will be submitted to HIQA in the NF39 quarterly returns as required.

Proposed Timescale: 11/04/2018

Theme: Safe Services

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

The inspector was informed that it had been identified by the person in charge that there had been a number of safeguarding incidents between residents which had not been notified to HIQA as required.

8. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

The PIC has met with the DO and the provider Nominee and discussed these incidents. Following this meeting the incidents were captured on an NF06 report and notified to HIQA.

The PIC met with all staff to discuss the reporting and documenting of safeguarding incidents and the DO also came on site to meet with staff and to answer any questions.

Proposed Timescale: 11/04/2018

Outcome 12. Medication Management

Theme: Health and Development

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

Residents had not been assessed as to their capacity to self-administer medicines.

9. Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

In line with the organisational policy the PIC has ensured that all residents have had a self-administration risk assessment completed.

Proposed Timescale: 11/04/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The person in charge did not have assistance from a dedicated post-holder in her managerial duties and this was significant given that she managed more than one designated centre.

10. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of

the designated centres concerned.

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

The provider nominee has liaised with the HR department a commitment has been made to allocate a PPIM to this centre.

Proposed Timescale: 30/04/2018

Theme: Leadership, Governance and Management

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

The most recent six monthly inspection failed to identify some a key findings of this inspection in the area of the identification, reporting and notification of peer-to-peer safeguarding concerns.

11. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

The organisation has committed to ensuring a more robust approach in identifying findings in the six monthly inspections.

The PIC met with the Designated Officer and a plan was made to meet with all staff to outline the importance of notifying all incidents of peer to peer abuse to relevant stakeholders.

All staff have received training in safeguarding the vulnerable adult.

All PIC's in the organisation met with the DO who again reiterated the importance of reporting all incidents of abuse and the systems for reporting these incidents.

Proposed Timescale: 11/04/2018

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 de-escalation and intervention, fire safety and manual handling.

12. 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:

The PIC has ensured that these identified staff have been booked in for the relevant refresher training.

Proposed Timescale: 30/04/2018

Theme: Responsive Workforce

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

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 September 2017 which highlighted that a formal process was required.

13. 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 has developed a draft policy on supervision. The organisation has engaged with an external agency who has facilitated a clinical peer to peer supervision for the nursing staff on a pilot scheme. The facilitator met with level 2 managers on the 27/3/18 to commence this work.

Proposed Timescale: 30/06/2018

Outcome 18: Records and documentation

Theme: Use of Information

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

A number of the required policies had not been reviewed since 2014.

14. Action Required:

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

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

The Policy development committee have reviewed policies. Policies which required updating has been approved for circulation a print run date is currently been identified.

Proposed Timescale: 30/04/2018

Theme: Use of Information

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

There was inconsistency in the frequency of recorded nursing care notes about residents and respite recipients and their day-to-day experience while in the care of the centre. The rationale for administering PRN medicines was not always clearly documented along with the effectiveness of the medicine when administered.

15. Action Required:

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

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

The PIC met with all staff and it has been agreed that a daily note will be documented for each resident.

Proposed Timescale: 11/04/2018