

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	North County Cork 1
Centre ID:	OSV-0003306
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Lead inspector:	Caitriona Twomey
Support inspector(s):	Kieran Murphy
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	1

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 04 January 2018 09:50 To: 04 January 2018 17:25

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

Outcome 02: Communication
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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was the second inspection of this centre carried out by the Health Information and Quality Authority (HIQA). The centre was registered as a designated centre following an inspection in December 2014. This unannounced, one day inspection took place to monitor ongoing regulatory compliance. The centre was inspected against 12 outcomes.

The centre was managed by Cope Foundation who provided a range of day, residential and respite services throughout Cork city and county.

Description of the service:

The centre was a detached, two storey house, located on the outskirts of a town in county Cork. Although the centre could accommodate 10 residents, on the day of the inspection nine residents lived there. It was noted that since the previous inspection, some of the residents had increasingly complex support needs, often regarding healthcare. The centre had seven bedrooms, two of which were double occupancy.

The bedrooms were located in a one storey area of the centre, adjoining a two storey building. The ground floor of the house comprised a visitors' room, dining room, kitchen, utility area, sitting room, and staff office. Residents did not have access to the second storey of the building. Staffing was provided in the centre 24 hours a day, seven days a week.

How we gather our evidence:

As part of the inspection, the inspectors met with the nine residents living in the centre, the person in charge, and five other members of the staff team. The inspectors reviewed documentation including personal plans, healthcare plans, medication records, training records, fire safety information, risk assessments, the centre's statement of purpose, a report completed by the provider following an unannounced inspection of the centre, and the centre's most recent annual review.

Overall judgment of our findings:

There were a number of examples of good practices seen. It was observed by inspectors that residents' personal care was very well attended to and staff interacted with residents in a respectful and caring way. Staff working in the centre appeared to know the residents well. It was also noted that residents had been involved in what was called an "interactivity morning" in the local community centre the previous month. This event was coordinated with the local secondary school. There was written information and photographs available in the centre regarding the event. Residents appeared to have really enjoyed the day. Staff spoke about ongoing collaboration and time spent with students from the local school.

However, there were areas that required improvement. Of the 12 outcomes inspected, six were at the level of major non-compliance. On the day of the inspection the provider was issued with an immediate action in relation to Outcome 17.

Findings of major non-compliance related to:

- As on the previous inspection, it was observed that fire doors were being kept open with wedges. In addition, inspectors observed that all doors throughout the building did not appear to be fire rated doors and so would also be ineffective in the event of a fire (Outcome 7: Risk Management).
- There was no evidence of recent assessment to identify and alleviate the cause of challenging behaviour. A number of restraint procedures were identified in the centre that had not been reported to HIQA or implemented following the organisation's own policy. It was also not possible to determine if staff had received training in safeguarding or behaviours that challenge, as is required by the regulations (Outcome 8: Safeguarding and Safety).
- Improvement was required in relation to the development and review of prescribed emergency treatment protocols and care planning for assessed healthcare needs (Outcome 11: Healthcare).
- There were inadequate security systems in place for storing a medicine that was on Schedule 2 of the Misuse of Drugs Act (commonly referred to as controlled drugs; Schedule 2 drugs). In addition, there were serious shortcomings in the monitoring and checking of the stock balance of this medicine (Outcome 12: Medicines Management).

- Given the number of non-compliant findings identified during the inspection and their significance, inspectors were not assured that the provider could ensure the effective governance, operational management and administration of the designated centre. As outlined throughout the report, areas for improvement included fire safety and oversight of risk in the centre, staff awareness and reporting of restrictive procedures, medication management, residents' healthcare needs, staffing and staff training, communication supports for residents, personal planning including multidisciplinary input, updating of residents' support plans, and upkeep of the premises (Outcome 14: Governance and Management).
- There were inappropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. An immediate action was issued as it was identified that times there were no staff on duty in the centre who could administer emergency medications prescribed to residents. From the information available to inspectors, it was not possible to identify if staff had received appropriate training to meet the needs of the residents (Outcome 17: Workforce).

Five of the remaining six outcomes were at the level of moderate non-compliance. The remaining outcome was found to be substantially compliant.

The reasons for these findings are explained under each outcome in the report and the actions required of the provider can be found in the action plan at the end of the report.

A representative of the provider attended a feedback meeting in the HIQA office in Mahon, Cork the day after the inspection.

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 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:

Staff were aware of the communication approaches of residents, however there were no recent assessments regarding residents' communication abilities and support needs.

The majority of residents had significant needs in the area of communication. There were communication passports for five of the residents living in the centre completed by staff of the Cope Foundation speech and language therapy department. These were stored up high in the dining room and were therefore inaccessible to residents. Inspectors reviewed these documents and identified, following observation and discussion with staff, that the information contained in them was many years out of date. Some of these documents made reference to the use of Lámh (a manual sign system used by children and adults with intellectual disability and communication needs in Ireland) to support residents. Inspectors did not observe the use of Lámh during the inspection.

In a sample of files reviewed by inspectors, each resident had a communication profile and communication of need document completed or reviewed by a staff member in the previous twelve months. There was no evidence of any communication assessments completed by an appropriate health care professional. During the inspection, inspectors observed a staff member using photographs to support communication with residents. However, from observation and in the absence of assessment, it was unclear if these communication supports were appropriate to residents' needs. Inspectors also observed the incidental use of some objects of reference to support communication. For example, a ball to indicate a particular activity. The majority of interactions between staff and residents observed by inspectors were solely verbal in nature. From the information available in the centre, it was unclear if staff had received training in communication approaches. Staff training will be discussed further in Outcome 17.

There was a visual display in the dining area of the staff working in the centre on the day. This was updated during the inspection. Staff were observed to be respectful in

their interactions with residents. Residents appeared to be more engaged in meaningful interaction when support was provided on a one-to-one basis.

Residents had access to television and radio in the centre.

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):

No actions were required from the previous inspection.

Findings:

Each resident's assessed needs were set out in an individualised personal plan. However, improvement was required in relation to assessments of social care and personal needs, including residents' participation in this process and subsequent reviews.

Inspectors reviewed a sample of residents' records. For each resident there were two sets of records, the person centred planning folder that contained the resident's healthcare plans and person centred planning reviews; and a separate file for medical, healthcare records that included records of reviews by medical doctors, consultant letters and blood test results.

Assessments were in place for the majority of identified healthcare needs. There was evidence of input from the relevant healthcare professionals in relation to the assessment of residents' needs. For example, in one resident's healthcare file there had been a comprehensive multidisciplinary review which had been used to inform practice, identify required therapies, and to meet the resident's healthcare needs. Assessments and plans relating to residents' healthcare needs are discussed further in Outcome 11.

In relation to social care needs, personal goals and objectives were outlined in all personal plans. However, Cope Foundation in their own six monthly review of the safety and quality of care in the centre, carried out in September 2017, identified that the process for identifying residents' personal goals required review. On the inspection it

was found that there was no evidence of residents' involvement in agreeing and setting these goals. In addition, inspectors observed that in some residents' social care plans the goals related to residents' basic nursing care needs and did not focus on the residents' personal development or preferences. There was evidence of a multidisciplinary review in one of the files reviewed by inspectors. However, the focus of this review related solely to the resident's physical health. There was no evidence of multidisciplinary input into the personal and social care needs of residents. The person in charge told inspectors that a multidisciplinary review of all resident's personal plans was scheduled for 25 January 2018.

Inspectors were told that one resident had been admitted to hospital to treat a healthcare need. While there was a discharge letter on file from the speech and language therapist in the treating hospital there was no discharge letter from the treating medical or nursing staff following this hospitalisation in the resident's file. There was no evidence that the resident's care plans were updated or reviewed following this hospital admission.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The centre was decorated in a homely manner. However, parts of the premises were inaccessible to residents, poorly maintained and in need of repair.

There were three large communal areas in the centre, a visitors' room, sitting room and dining room. These rooms were decorated in a homely manner with pictures, photographs and Christmas decorations. A number of seats in the visitors' room and dining room required repair. Two large pieces of equipment that were no longer required in the centre were stored in the living room. These issues had been identified during the six monthly visit completed by Cope Foundation in September 2017. The person in charge advised inspectors that following that visit, the organisation's facilities manager had visited the centre.

There were two rooms with shower facilities and three rooms with toilet facilities in the

centre. Five residents had their own bedrooms. There were two double occupancy bedrooms. The bedrooms were personalised and decorated to residents' preferences. Staff reported to inspectors that a relative of one of the residents sharing a bedroom requested that this situation be reviewed. There was no evidence of this review in the centre or reference to the relative's request in the risk assessment in the centre regarding shared bedrooms. There were screens available in both shared bedrooms to provide some privacy to each resident, as required. Each resident had storage facilities in their bedrooms for their belongings. There were handrails fitted in parts of the centre to support residents with mobility challenges.

The residents were not permitted to access the upstairs rooms in the centre at any time. A secured gate was installed at the base of the staircase. Various reasons for this were provided by staff to inspectors. Residents' access to the upstairs areas was not included on the centre's risk register. There was a kitchen in the centre adjoining the dining room. The kitchen was accessible by two doors, both of which were fitted with keypads. Residents could access the kitchen when with staff members. Residents' access to the kitchen was also not included on the centre's risk register. Similarly, laundry facilities in the centre were accessed through a door fitted with a keypad.

On the day of the inspection, the centre was very warm. Staff reported to inspectors that they were unable to regulate the temperature in the centre and required maintenance workers to address this issue. They reported that in recent weeks the centre had been too cold and that the temperature was adjusted as a result.

There was a large garden in the centre that had been developed with contributions from the local community. Staff reported that many of the residents in the centre enjoyed spending time in the garden, especially in the spring and summer months when gardening was facilitated. Inspectors noted that residents could not independently access the garden due to restrictions in the centre. These and other identified restrictions will be discussed further under Outcome 8.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

Improvement was required in relation to how the designated centre was managing risk

and fire safety. In particular, there were inadequate arrangements in place to contain an outbreak of a fire and to give warning of fire. Improvement was also required in relation to risk assessment.

The centre had a separate risk register in place which was designed to log all the hazards that the centre was actively managing. Cope Foundation in their own six monthly review of safety and quality of care in the centre, completed in September 2017, identified that the risk register was not being completed accurately. On this inspection it was also found that the process for risk assessment for specific hazards on the risk register was not always completed to accurately reflect the current risk rating. There were 14 items on the active risk register. In practice the risk register identified health and safety issues and did not identify centre specific issues. For example, one of the issues that had been identified by staff was the lack of opportunity for residents to engage in social activities due to staff shortages. However, the risk register did not include this issue. In addition, it was also unclear if, or how, hazards on the risk register were being escalated to the management team of Cope Foundation.

In relation to incident reporting, Cope Foundation in their own six monthly review of safety and quality of care in the centre, completed in September 2017, identified that there was no evidence of learning from incidents. On the inspection it was found that the records of incidents were being maintained in a haphazard manner and inspectors could not be satisfied if all incidents were being accurately recorded. Of the records seen by inspectors there had been 13 recorded incidents in 2017, three of which were resident falls; one incident of a staff member burning themselves; and the remainder of incidents related to residents hitting other residents and staff, or residents injuring themselves.

As on the previous inspection it was observed that fire doors were being kept open with wedges. This meant that doors could not close in the event of a fire and could not be guaranteed to restrict the spread of fire and smoke in the event of a fire emergency. Inspectors also observed that all doors throughout the building did not appear to be fire rated doors and so would also be ineffective in the event of a fire.

According to the records available to the inspectors the main fire safety installations of fire alarm panel and emergency lighting were not within their statutory inspection schedules. This meant that the systems that gave warning in the event of a fire were not serviced as required. From the information available in the centre, it was unclear if staff had received suitable training in fire precautions as is required by Regulation 28. Staff training will be discussed further in Outcome 17.

In addition to providing personal care to residents and the preparation of all meals, staff also had responsibility for the daily cleaning and all laundry in the centre. Staff spoken with were knowledgeable about cleaning and control of infection. The centre was visibly clean with a cleaning schedule identifying areas to be cleaned and cleaning frequencies.

Judgment:

Non Compliant - Major

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 organisation had policies and procedures in place regarding behavioural support, rights' restrictions and safeguarding. However, it was not possible to determine if staff had received training in these areas, as is required by the regulations. There was no evidence of recent assessment to identify and alleviate the cause of challenging behaviour. In addition a number of restraint procedures were identified in the centre that had not been reported to HIQA or implemented following the organisation's own policy.

The organisation had policies in place regarding the provision of behavioural support and the use of rights' restrictions. From the information available in the centre, inspectors identified that two of the 18 staff that featured on the rosters in the centre had attended training on how to respond to behaviour that is challenging, including de-escalation and intervention techniques. It was unclear if the remaining 16 staff had received suitable training in this area, as is required by Regulation 7. Staff training is addressed further under Outcome 17.

Through a review of notifications submitted to HIQA, observation during inspection, and discussion with the person in charge, it was identified that three of the residents in the centre at times engaged in behaviours that were challenging. Inspectors reviewed the personal plans of these three residents. There was no behaviour support assessment or plan for one of the residents. Another had an assessment and support plan dated September 2014, however the behaviour assessed and referred to in the support plan was different to that reported to, and identified by, inspectors. For the third resident, there was an assessment and behaviour support plan, however it was dated April 2014.

Inspectors identified the routine use of a number of environmental restrictive practices in the centre that had not been notified to HIQA. These included the use of keypads on doors to the kitchen, laundry area and office; many locked cupboards within the centre; locked doors to access the enclosed outside areas and garden; and a gate at the foot of the stairs. There was no evidence in the centre that the organisation's own policy in relation to rights' restrictions had been followed in regard to these environmental restraints.

There was a policy in the centre regarding the prevention, detection and response to abuse. From the information available in the centre, inspectors identified that six of the 18 staff that featured on the rosters in the centre had attended safeguarding training. It was unclear if the remaining 12 staff had received suitable training in safeguarding as is required by Regulation 8. In a sample of residents' files reviewed by inspectors, each resident had an intimate care plan that had either been developed or reviewed by a member of staff in the previous 12 months.

The identified issues regarding the need for updated information to be included in residents' behaviour support plans, the lack of notification of environmental restraints to HIQA, and the lack of implementation of the organisation's own policy in relation to these restraints were identified in the six monthly review completed by Cope Foundation in September 2017.

Judgment:

Non Compliant - Major

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:

It was identified that residents' opportunities for new experiences, social participation, education, training and employment were limited.

On the day of inspection, inspectors observed that some residents did not participate in any activities for the majority of the day, instead sitting in various areas of the house. Some other residents did participate in group activities provided such as painting and bocce. On review of residents' personal plans, participation in meaningful activities was a goal for one resident. However, it was identified that for one month in 2017 the progress towards achieving this goal was going for a "spin with staff". The resident's other goal related to spending more time with family which he had been supported to achieve by the activities supervisor. In the six monthly visit completed by Cope Foundation in September 2017, it was identified that there was a need to reassess all residents' activation needs and resources required to meet these needs.

One of the nine residents attended a day centre in another town, five days a week. Staff informed inspectors that one of the other residents had previously attended a day centre

but did not have funding for transport to attend while living in the centre. There was no evidence of assessments to establish residents' educational or training goals.

There was an activities supervisor in the centre on the day of the inspection. The activities supervisor worked in the centre for 20 hours a week. She advised inspectors that previously this support was provided for 32 hours a week. When speaking with inspectors, the activity supervisor outlined the role of two volunteers in supporting activities, especially those based in the community. The activities supervisor worked in four week blocks, working on days at the start of the week for one block and on the days at the end of the week for the following four weeks. This meant that swimming in the organisation's pool was available as an activity four weeks out of eight. However, the activities supervisor explained that due the support needs of residents when in the pool and the availability of a volunteer, most often each resident who wanted to go swimming would get the opportunity once every eight weeks. The activities supervisor reported that each resident appeared to enjoy spending time outside of the centre and on most days that she was in the centre it was possible to support each resident who wished to go out, to do so. The activities supervisor spoke positively with inspectors regarding a training day she had attended in December 2017 with other activities supervisors in the organisation. She reported that this session had generated ideas for new activities to introduce in the centre. Evidence of one such activity was seen by inspectors.

Staff spoke with inspectors about collaboration with a local secondary school. This resulted in residents regularly spending time with students outside of the centre. Staff reported that residents appeared to enjoy these sessions and were more likely to engage and participate in activities when outside of the centre. An "interactivity morning" had taken place in the local community centre before Christmas. There was written information and photographs available in the centre regarding the event. When with inspectors, one resident smiled and communicated positively about this event.

Judgment:

Non Compliant - Moderate

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:

Improvement was required in relation to care planning for assessed healthcare needs, including dementia and end-of-life care. Protocols regarding prescribed emergency

treatment either required review or development.

In the sample of residents' healthcare records seen by inspectors, each resident had access to a local general practitioner (GP). There was evidence of good access to specialist care in psychiatry, with a consultant psychiatrist available to residents, as required. Staff spoke to inspectors about an improvement in two residents' quality of life following recent medical and medication reviews.

In relation to the assessment of residents' needs, inspectors were told that a number of residents had a diagnosis of dementia. However, there were no healthcare plans relating to dementia in residents' healthcare files. This was highlighted in Cope Foundation's six monthly report completed in September 2017. In addition, there was no evidence of input from specialists in dementia to guide appropriate care, therapies and activities to promote quality of life and wellbeing for these residents. There was an undated hospital passport in one of the residents' files reviewed by inspectors. This document was not evident in the other files reviewed. The absence of hospital passports was also identified in Cope Foundation's six monthly visit report completed in September 2017.

There was evidence that residents were being referred to, and reviewed by, consultant specialists as required, particularly in relation to neurological conditions. However, the protocols and care plans in relation to the management of epilepsy did not accurately reflect residents' current medicines prescription. Inspectors also noted that one resident was prescribed oxygen. However, there was no guidance in place for the administration of the oxygen and staff spoken with were unclear as to when to administer oxygen. It was identified that there was not always a staff member working in the centre who was trained in the administration of emergency epilepsy medication or oxygen. This is addressed further in Outcome 17.

Inspectors saw that, based on a sample of records reviewed, residents' wishes in relation to care at times of illness or end of life had not been ascertained. This was particularly relevant as a number of residents had experienced a significant deterioration in their health and therefore information would not be available to guide staff in meeting residents' needs whilst respecting their dignity, autonomy, rights and wishes. During the review of one resident's file, inspectors identified conflicting information regarding the resuscitation status of the resident in a note from a doctor in the acute hospital and in a record of a Cope Foundation multidisciplinary team meeting. There was no evidence of discussion with the resident regarding their resuscitation status.

In addition to providing personal care to residents and the cleaning of the house, staff also had responsibility for the preparation and cooking of meals for all residents. A number of residents had dysphagia (eating, drinking and swallowing) difficulties and had recommendations in place following an assessment by a speech and language therapist. There were also recommendations in place from a dietitian in relation to residents' nutritional needs. Staff were observed to be following the recommended guidelines in relation to food preparation and nutrition. Staff were also observed to support residents appropriately at mealtimes.

Judgment:

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):

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

Findings:

Improvement was required in relation to medicines management practices and in particular the management of medicines on Schedule 2 of the Misuse of Drugs Act (commonly referred to as controlled drugs; Schedule 2 drugs).

One of the residents required medicine for the management of pain. This medicine was on Schedule 2 of the Misuse of Drugs Act (commonly referred to as controlled drugs; Schedule 2 drugs). However, there were inadequate security systems in place for storing this medicine as it was not locked in a separate cupboard or container from other medications to ensure further security. In addition, there were serious shortcomings in the monitoring and checking of the stock balance of this medicine as the balance had not been checked since 12 December 2017 which was three weeks before this inspection.

Some medicines needed to be stored in a fridge. However, there was not a separate fridge available for medicines in the centre. As a result they were stored in the fridge in the kitchen which also contained the food and drinks for the house. This practice meant that the stability of these stored medicines could not be guaranteed.

Medicines for residents were supplied by a local community pharmacy directly to the centre. Staff who spoke to inspectors outlined the checking process in place at that point to confirm that the medicines delivered corresponded with the medicine prescription records. However, the recording of this checking process required improvement so that an accurate record was maintained of what was received from, and returned to, the pharmacist.

A sample of medicine prescription and administration records was reviewed by an inspector. Medicine prescriptions were written by a medical doctor. Medicine administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. However, the inspector identified a number of errors that had not been previously identified by the systems in place at the centre. This included the withholding of a medicine as a syringe was not available for staff to give the medicine as prescribed. In addition, as identified in the last inspection, on prescription forms it was not always specified that medicines

were to be administered in a modified form (crushed), although this was the practice in the centre.

While a medicines usage review report had been completed by the pharmacist in December 2017, a systemic review of all residents' medicines administration records was required to ensure that all medicines were administered as prescribed.

It was an action outlined in Cope Foundation's six monthly report, completed in September 2017, that the person and charge and provider nominee were to discuss medication management within the centre.

Judgment:

Non Compliant - Major

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):

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

Findings:

The statement of purpose did not include all of the information required by Schedule 1 of the regulations. This was identified in the six monthly inspection of the centre completed by Cope Foundation in September 2017. In addition, the management complement for the centre outlined in the statement of purpose required review.

Judgment:

Substantially 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):

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

Findings:

The governance and oversight of the centre required improvement to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. Given the number of non-compliant findings identified during the inspection and their significance, inspectors were not assured that the provider could ensure the effective governance, operational management and administration of the designated centre. As outlined throughout the report, areas for improvement included fire safety and oversight of risk in the centre, medication management, residents' healthcare needs, staffing and staff training, communication supports for residents, personal planning including multidisciplinary input, upkeep of the premises, and staff awareness and reporting of restrictive procedures.

The person in charge met the criteria as outlined in the regulations regarding management experience. As well as this centre, the person in charge fulfilled this role for two other designated centres. She also reported ongoing involvement in a day centre although she no longer held a management role in that service. The person in charge was based approximately 25km away from this centre. Following the December 2014 HIQA inspection, the provider stated that the person in charge would have capacity to be in the centre two to three days a week. From speaking with a number of staff it was identified that the person in charge was available by telephone every day, however was most often in the centre one day a fortnight. When speaking with inspectors, a number of staff were not clear as to who was the person in charge in the centre.

Inspectors' findings indicated that the centre was not resourced to ensure the effective delivery of care and support in the centre in line with its statement of purpose. As outlined under Outcomes 7 and 11, as well as supporting and meeting the needs of residents, staff also had responsibility for all household tasks. It was suggested in the September 2017 six monthly visit report that the centre could avail of staff for domestic duties. As outlined in Outcome 10, resident's participation in meaningful activity was strongly influenced by the availability of a part-time activities supervisor and volunteers. Staffing is discussed further under Outcome 17. The annual review completed by Cope Foundation stated that there were insufficient resources in the centre to meet the needs of the residents.

There was an annual review of the quality and safety of care in the designated centre. The report was completed in December 2017, following a visit in November 2017. This review did not provide for consultation with residents and their representatives, as is required by Regulation 23.

There was evidence of the provider visiting the centre in September 2017 which resulted in a report on the safety and quality of care and support provided in the centre. There was no evidence of any other unannounced visits to the centre in 2017. An action plan was generated following the September visit. However it was not documented who was

responsible for overseeing the completion of the various actions, the timeframe for completion or any progress made. As was highlighted throughout this report, a number of the findings from this inspection were consistent with those identified by Cope Foundation 15 weeks previously.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

There were not appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. An immediate action was issued as it was identified that at times there were no staff on duty in the centre who could administer emergency medications prescribed to residents. From the information available to inspectors, it was not possible to identify if staff had received appropriate training to meet the needs of the residents.

On the day of inspection there were additional staff rostered to work in the centre to support one resident to attend an appointment in Cork city. The activities supervisor was also working in the centre. Despite this, staff reported, and inspectors observed, that given the support needs of the residents in the centre, the majority of staff time was taken up fulfilling residents' basic support needs. As a result, staff were unable to address residents' other needs such as participation in meaningful activity in the centre or local community. Staff also highlighted that not all staff could drive the centre's vehicle, further limiting the ability to support community participation. There were two records of staff meetings in the centre in 2017; one in February and the other in December.

Staff reported that the staff rota was developed on a week-to-week basis. Of the 18 staff members included in the rosters viewed by inspectors, the majority were on relief contracts. Inspectors were informed that the planned staffing requirement was three staff on the day shift and two at night. Inspectors reviewed a sample roster for one week in December 2017. For three out of seven day shifts there were two staff working. As a result, it was identified that contingencies in place to cover staff on leave were

ineffective.

In the centre, only nursing staff were trained in the administration of emergency medications prescribed to residents. In the sample week reviewed by inspectors it was identified that on one day that week a nurse was only available from 9am to 5pm. On another day that week there was no nursing staff on duty during the day. It was also identified that none of the staff who worked the night shift in the centre were trained in the administration of emergency medication. The provider was issued with an immediate action regarding this.

Inspectors reviewed the staff training records in the centre. These records were incomplete and only related to five of the 18 staff. Separate information was available regarding safeguarding training completed by six of the 18 staff in February 2016. Inspectors requested an up-to-date training matrix from the person in charge on the day of the inspection. At the time of writing the report, the training matrix had not been submitted to HIQA.

Judgment:

Non Compliant - Major

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):

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

Findings:

This outcome was not inspected in full. Through the review of residents' personal plans and other documentation in the centre, inspectors identified areas for improvement.

The system of records management did not adequately ensure that relevant healthcare information was available to plan care for residents. This had also been found on the previous inspection. In addition, there were issues in the management and maintenance of other records including fire safety records.

In healthcare files seen by the inspectors, relevant documentation was filed in a haphazard manner in a plastic folders located in the back of residents' healthcare records, including results of blood tests and recent letters from doctors.

In addition, there were issues in the management and maintenance of other records. For example, there were two fire register books on site with some records being kept in the "older" book, for example the daily inspection of means of escape routes, and other records being kept in the "newer" book including the testing of emergency lighting.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003306
Date of Inspection:	04 January 2018
Date of response:	22 March 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 02: Communication

Theme: Individualised Supports and Care

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

There were no communication assessments or up to date communication passports for any of the residents in the centre. It was therefore not clear if the communication supports provided were in accordance with the residents' needs.

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 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 has liaised with CNS in communication who has agreed to facilitate onsite communication workshops to support staff in developing and update communication passports. The CNS will also deliver training in communication approaches specific to resident's needs. (commenced on 20-02-18)

Two resident's passports has been reviewed and updated and a robust schedule is in place to complete all remaining residents' passports. (13-04-18)

All residents' communication profiles have been reviewed and updated. (completed)

Familiar staffs have commenced compiling relevant information and photographs meaningful to each resident

Proposed Timescale: 13/04/2018

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:

Residents' personal plans did not outline supports to maximise each resident's personal development.

2. Action Required:

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

The PIC and PPIM will ensure a comprehensive assessment of needs will be carried out for each resident to reflect the resident's wishes and aspirations in consultation with relevant members of the multi-disciplinary team and their family representative.

A robust schedule is in place to complete Personal Plans. The PIC has identified a team to oversee that Personal plans are completed within the specific timeframe.

Three personal plans will be completed by 21-03-2018

Remainder of Personal plans will be completed by 31-05-2018

Proposed Timescale: 31/05/2018

Theme: Effective Services

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

There was no evidence of multidisciplinary review of residents' personal and social care

needs.

3. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

A multi-disciplinary team meeting has taken place on the 25-01-18

Proposed Timescale: 22/03/2018

Theme: Effective Services

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

There was no evidence of residents' or their representatives' participation in the review of the personal plans reviewed by inspectors.

4. Action Required:

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

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

The PIC will ensure that all personal plans are reviewed and developed in consultation with residents, family member/guardian and relevant members of the multidisciplinary team.

Personal centred planning workshops will be held for all staff.

A schedule will be developed with familiar staff of the team to ensure the resident's needs are met and goals identified are achieved within specific time frame.

A family forum will take place on the 27-02-2018, a schedule is in place to complete PCP.

Proposed Timescale: 31/03/2018

Theme: Effective Services

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

There was no evidence to indicate that a resident's care plans were updated or reviewed following a hospital admission.

5. Action Required:

Under Regulation 25 (2) you are required to: On the return of a resident from another designated centre, hospital or other place, take all reasonable actions to obtain all relevant information about the resident from the other designated centre, hospital or

other place.

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

In the event of a hospital admission, following discharge the PIC will ensure that all relevant information will be followed up and developed into a healthcare plan within the Personal Plan.

Proposed Timescale: As required following discharge post hospital admission

Proposed Timescale:

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Large parts of the centre were inaccessible to residents. There was no documented review of the centre's accessibility available on the day of inspection.

6. Action Required:

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

The PIC has arranged for a member of the Rights restrictive committee to do an audit of restrictive practices in use within the centre following the findings of this audit risk assessments will be carried out and relevant documentation related to the use of restrictive practices will be completed for the centre / resident.

Proposed Timescale: 28/02/2018

Theme: Effective Services

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

Parts of the centre were not kept in a good state of repair.

7. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

The PIC has requested the replacement of broken and worn furniture; same has been order and waiting delivery date. (completed)

Equipment no longer required by the centre has been since removed. (completed)
The facilities manager has completed a walk-through of the centre and identified works to be done. The maintenance team have put a schedule in place to complete actions from report of same.

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

Suitable heating was not available for residents in all parts of the centre used by them.

8. Action Required:

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

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

The facilities manager has been contacted re heating and same has been regulated to provide a more comfortable temperature of heat. The maintenance team demonstrated to staff on how to control the heating thermostat.

Proposed Timescale: 22/03/2018

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 risk register required review. In addition, it was found that the records of incidents were being maintained in a haphazard manner and inspectors could not be satisfied if all incidents were being accurately recorded.

9. 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 PPIM has reviewed and updated the risk register to include site specific issues relevant to the centre. On completion of Rights Restriction audit the risk register will be updated to reflect the findings.

The PIC has put in place a organised system to record, monitor and store documentation related to incidents within the centre. (completed)

Proposed Timescale: 05/03/2018

Theme: Effective Services

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

According to the records available to the inspectors the fire alarm panel and emergency lighting were not serviced within the required statutory timeframe.

10. Action Required:

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

The fire panel and emergency lighting have been inspected & serviced by an electrician service records available onsite.

Proposed Timescale: 22/03/2018

Theme: Effective Services

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

As on the previous inspection it was observed that doors in the centre were being kept open with wedges. Inspectors also observed that all doors throughout the building did not appear to be fire rated doors and so would also be ineffective in the event of a fire.

11. 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 PIC has reiterated with staff that the use of door wedges are not permitted within the centre door wedges found within the centre removed. A fire assessment survey was carried out on 12/01/18 by independent engineer. Following this survey, the facilities manager has compiled a spending cost for purchasing and fitting of fire doors and magnetic holders where required fire doors will be fitted by 31/05/2018.

Proposed Timescale: 31/05/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

A number of environmental restraints used in the centre were not applied in line with the organisation's policy.

12. 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 has arranged for a member of the Rights restrictive committee to do an audit of restrictive practices in use within the centre following the findings of this audit risk assessments will be carried out and relevant documentation related to the use of restrictive practices will be completed for the centre / resident.

Proposed Timescale: 05/03/2018

Theme: Safe Services

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

It was unclear if all staff had received suitable training in positive behavioural support, as is required by Regulation 7.

13. Action Required:

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

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

The PIC has reviewed training records , staff who require training in positive behavioural support will receive this training on Friday 2nd of March 2018 and Friday the 9th of March 2018.

Proposed Timescale: 09/03/2018

Theme: Safe Services

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

There were no current behaviour support assessments or plans for residents identified as at times engaging in behaviours that were challenging.

14. 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:

The PIC and PPIM have liaised with the positive behavioural support team and a member of the team has commenced reviewing and updating current behavioural plans. Following the MDT review the development of a behaviour support plan will commence for specific resident.

Proposed Timescale: 31/03/2018

Theme: Safe Services

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

It was unclear if all staff had received suitable training in safeguarding as is required by Regulation 8.

15. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

The designated officer will provide training to a number of staff on February 14-02-18 and remainder will attend training on 12th of March .

Proposed Timescale: 12/03/2018

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:

Resident's opportunities for new experiences, social participation, education, training and employment were limited.

16. Action Required:

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

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

The PIC has arranged for a PALS assessment to be completed for each resident and the 0.5 activation staff post will be filled to enable residents to further access and participate in meaningful social experiences within the community.

Following the Multidisciplinary Team review the PIC has advocated and secured a Day service for resident , 2 days a week with a view to progressing same to fulltime basis. (commenced 7-02-18)

Proposed Timescale: 19/03/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Protocols for assessed healthcare needs required development and review.

17. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

The PIC & PPIM have developed PRN protocols in relation to all relevant emergency treatment plans. The PIC and the PPIM are currently reviewing and updating the protocols in relation to health care needs.

Proposed Timescale: 31/03/2018

Theme: Health and Development

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

Residents' wishes in relation to the support to be received at the end of their lives had not been ascertained

18. Action Required:

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

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

The PPIM supported a family in discussing an end of life plan with the GP. The PIC will ensure that an end of life healthcare plan is developed following this consultation. The PIC and PPIM will address the end of life wishes of the resident during the person centred planning meeting

Proposed Timescale: 27/02/2018

Theme: Health and Development

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

Improvement was required in relation to the healthcare planning processes in the centre.

19. 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 PPIM supported a family in discussing an end of life plan with the GP. The PIC will ensure that an end of life healthcare plan is developed following this consultation.

The PIC will send a referral to the dementia team to assess residents presenting with this need.

Proposed Timescale: 22/03/2018

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:

In relation to medication on Schedule 2 of the Misuse of Drugs Act, practices in relation to administration and storage were not sufficient.

20. Action Required:

Under Regulation 29 (4) (d) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

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

The PIC has a sourced appropriate documentation to record the receiving and administering in relation to medication on schedule 2. (complete)

The PIC has also informed staff of the importance of the proper documentation of schedule 2 medications. (complete)

A DDA press has been installed for the appropriate storage of schedule 2 medication (complete)

The PIC, PPIM in conjunction with the pharmacist will carry out scheduled audits.

Proposed Timescale: 05/03/2018

Theme: Health and Development

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

Not all medications were indicated as needing to be modified on prescription sheets

although staff were administering the medications in a crushed format.

21. Action Required:

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

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

The PPIM has liaised with G.P. and pharmacist to amend medication administration records to reflect the correct format required by each resident.

Proposed Timescale: 22/03/2018

Theme: Health and Development

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

Practices regarding the ordering, receipt, disposal and reconciliation of medications and medication administration equipment required review.

22. Action Required:

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

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

The PIC has reviewed and implemented a robust process for medication management .

Proposed Timescale: 22/03/2018

Theme: Health and Development

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

Some medication needed to be stored in a medication fridge. However, a separate fridge was not available and these were stored in the main fridge in the centre. The temperatures on the fridge were not being recorded daily and therefore the stability of the stored medication could not be guaranteed.

23. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

Medication fridge was ordered and has been delivered.

Proposed Timescale: 22/03/2018

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not include all of the information required by Schedule 1 of the regulations.

24. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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 PIC has reviewed and updated the statement of purpose to reflect relevant information.

Proposed Timescale: 22/03/2018

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:

Given the number of non-compliant findings identified during the inspection and their significance, inspectors were not assured that the provider could ensure the effective governance, operational management and administration of the designated centre

25. 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 manager an agreement has been made to fill vacant and maternity leave posts and additional health care assistant post will be allocated to the centre the recruitment and filling of identified post will enable the PPIM to be supernumerary during the week to ensure effective governance and operational

practices within the centre. The PIC will have phone contact daily with the centre and will base herself in the centre two days a week.

Proposed Timescale: 19/03/2018

Theme: Leadership, Governance and Management

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

Only one six monthly visit report for 2017 was made available to inspectors.

26. Action Required:

Under Regulation 23 (2) (b) you are required to: Maintain a copy of the report of the unannounced visit to the designated centre and make it available on request to residents and their representatives and the chief inspector.

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

The provider nominee has liaised with the quality, risk and compliance team a member from this team will carry out an unannounced 6 monthly visit in March.

Proposed Timescale: 19/03/2018

Theme: Leadership, Governance and Management

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

The annual review did not provide for consultation with residents and their representatives.

27. Action Required:

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

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

The Quality Risk and compliance team will ensure prior to carrying out an annual review will liaise with PIC to communicate with families and consult with residents through satisfaction survey.

Proposed Timescale: 22/03/2018

Theme: Leadership, Governance and Management

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

There was no clear plan to address concerns identified during the unannounced six

monthly visit.

28. 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 provider nominee and the PIC will devise and action plan from the findings of the six monthly review

Proposed Timescale: 22/03/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

The skill mix of staff was not appropriate to the assessed needs of the residents as at times there were no staff on duty who could administer emergency medications prescribed to residents. In addition it was identified that the contingencies in place to cover staff on leave were insufficient.

29. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

Health care assistant received training on Jan 18th 2018 in the administration of rescue medications.

The provider Nominee is liaising with HR department to address skill mix and ensure appropriate staffing levels are available for the centre.

Proposed Timescale: 31/03/2018

Theme: Responsive Workforce

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

A planned and actual staff rota was not available to inspectors on the day of inspection.

30. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota,

showing staff on duty at any time during the day and night.

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

The PIC and PPIM will ensure that a planned and actual roster are available within the centre as per regulatory requirements.

Proposed Timescale: 22/03/2018

Theme: Responsive Workforce

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

From the information available on the day of inspection, it was not possible to determine if staff had accessed appropriate training.

31. 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 reviewed the training matrix and has identified the training needs of staff. The Pic has arranged the following training to ensure all staff have completed mandatory training

Mapa training Friday 3rd and Friday 9th of March

Manual Handling Thursday the 1st of March

Safeguarding Monday 12th of March

Communication information session 28th of March

Proposed Timescale: 28/03/2018

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:

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

32. 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 residents health files are being reviewed and a robust system will be put in place to

ensure documentation is stored in an orderly manner.

Proposed Timescale: 22/03/2018

Theme: Use of Information

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

There were issues in the management and maintenance of other records including fire safety records.

33. Action Required:

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

The PPIM has filed the older fire register book and has informed all staff on the importance of completing the relevant sections of this book daily/weekly.

The PPIM has reiterated to staff the importance of the appropriate storage of fire safety equipment records.

Proposed Timescale: 22/03/2018