



Report of an inspection of a Designated Centres for Disabilities (Adults)

Name of designated centre:	Cork City North 18
Name of provider:	COPE Foundation
Type of inspection:	Unannounced
Date of inspection:	26 February 2018
Centre ID:	OSV-0005628
Fieldwork ID:	MON-0023725

About the designated centre

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

The Cope Foundation had produced a document called the statement of purpose, as required by regulation, which described the service provided. The statement of purpose identified that the centre could provide a home to 18 adult residents with an intellectual disability. On the date of inspection there were nine people living in one bungalow with eight living in an adjacent bungalow on a campus setting in the community. Both bungalows were purpose built and were accessible to all including accessible bathroom/shower facilities. Each resident was encouraged and supported to personalise their bedrooms with pictures, ornaments or any items they chose. The communal space in the houses included a large sitting room, spacious sun rooms, separate dining rooms and kitchens. The stated aim and objective of the centre "was to promote a welcoming and homelike environment ensuring always that residents' dignity and safety was promoted".

The following information outlines some additional data of this centre.

Current registration end date:	
Number of residents on the date of inspection:	17

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
26 February 2018	12:00hrs to 18:30hrs	Kieran Murphy	Lead

Views of people who use the service

The inspector met with 15 of the residents living in the centre. Many of the residents had lived in the centre for over 20 years and some had complex health care needs with an increasingly high level of support required. The residents spoken with said they were happy living in the centre and enjoyed lots of activities including bowling, swimming and doing things in the day service. There had been an Activities Coordinator appointed for the centre in September 2017 and the inspector noted that there more individualised one-to-one social development programme for residents had been developed. For example, one of the residents who an interest in gardening had developed a sensory garden and had planted flowers and bulbs during the winter. This resident told the inspector that they really liked the garden. Another resident showed the inspector an identified sensory space that had been developed for them and that they liked relaxing in.

Capacity and capability

Overall in relation to Capacity and Capability it was found that there was a good governance structure in place. In addition it was found that based on the assessed needs of residents, there were sufficient staff with the right skills, qualifications and experience to meet those needs. This was a focused inspection and was primarily concerned with identified restrictions on residents' lives, quality of life for residents, staffing levels and the governance arrangements in the centre.

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

The governance arrangements for this centre included oversight by a regional manager, a qualified nurse in intellectual disability. In December 2017 HIQA had been notified that there was a vacancy for the role of Clinical Nurse Manager II (CNMII) which was also the role nominated as the person in charge of the centre. In the interim the Cope Foundation had introduced suitable arrangements with the appointment of an acting CNMII who was an experienced nurse in intellectual disability and who knew all the residents extremely well. On the date of inspection, 26 February 2018, a new person in charge had been appointed and had started on that date but for the purposes of the inspection the interim arrangements were still in place with the acting CNMII in post. The acting CNMII had been supported by an experienced staff team including a nurse manager, staff nurses and health care

assistants.

The provider had ensured that an annual report in relation to the quality and safety of care in the centre had been completed in November 2017. There was a prepared written report available in relation to the "themes" that had been reviewed including: individualised supports and care, effective services, safe services, health care, leadership, use of resources, workforce and information. This review had an action plan to address any deficiencies identified. It was noted that some but not all of the deficiencies had been adequately addressed including issues relating to person centred care planning.

In relation to staffing an actual and planned staff rota was maintained. A copy of this rota was available in a picture format in both houses so that residents were aware of which staff were on duty. The inspector also met with staff and observed their respectful interactions with the residents. Any staff member spoken with was very knowledgeable of residents' preferences and committed to supporting residents to have a good quality of life. It was noted that experienced staff nurses had been "seconded" to the centre in the last six months with the result that there had been an increased oversight of the care being provided in the centre. There had also been an increase in staffing numbers, particularly during the day when there had been an increase from a minimum of two staff to three staff. Staff spoken with said to the inspector that this increase in staffing had led to improved outcomes for residents, particularly in relation to more activities in the community. It was noted that there was one full-time "awake" staff at night, with support available from a nurse and a senior nurse manager from another centre on the campus.

Regulation 15: Staffing

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

Judgment: Compliant

Regulation 23: Governance and management

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

Judgment: Compliant

Quality and safety

Overall in relation to Quality and Safety it was found that a priority for the service had been to support residents to engage in meaningful activities during their day and it was observed that this had commenced with the potential to greatly improve the quality of life for residents in this centre. Individualised supports had been implemented often in consultation with other health care professionals like the Occupational Therapist. For example, one resident had an identified sensory support need and a separate sensory space had been developed for them. The development of this space was in the initial stages and the resident showed the inspector the area that they like relaxing in. However, improvement was required to ensure that restrictions were being applied in accordance with policy and evidence based practice. Some improvement was also required to the personal planning process.

It was a requirement of the regulations that all serious adverse incidents, including allegations of abuse, were reported to HIQA. There were four significant incidents submitted to the Chief Inspector since November 2017. Documentation in relation to these incidents was reviewed during the inspection. It was noted that following one incident, the matter of an inappropriate placement of two residents had been presented to the Cope Foundation Adult Forum in order to seek a transfer to other centres that could better meet both residents' needs. The outcome from this Adult Forum placement request was that the organisation did not have an alternative suitable placement available. At the inspection the regional manager outlined that these placements would be reviewed by organisation in 2018 as part of an application for funding for de-congregation of residents from residential care. In the interim safeguarding plans were in place for both residents to protect themselves and other residents in the centre.

It was observed by the inspector that in the last year a number of restrictions had been removed including the removal of an alarm from one resident's bedroom. The provider had notified HIQA on a quarterly basis of any occasion on which restraint was used (such as physical, environmental or chemical). There was a COPE Foundation policy for the protection of a person's human rights when considering the use of a rights restriction. There was a register of all restrictions in the centre and all restrictions were to be implemented on the recommendation of the "person's support team" as outlined in the policy. In November 2017 the Rights Review Committee had completed an audit in this centre and reviewed rights restrictions in relation to four residents. The Rights Committee review found that improvement was required in relation to the process for the implementation of restrictions. Since November improvements had been implemented. However, the inspector was not satisfied that all restrictions were being risk assessed and reviewed as required by the Cope Foundation policy. For example, one resident was prescribed 'as required' medicine (PRN) to be used to relieve agitation. This was not approved as a restriction, a risk assessment was not available in relation to the use of the 'as required' medicine and a protocol was not in place for its administration. In addition, the inspector was also not satisfied that each restriction was being reviewed

regularly as required by the policy.

Each resident had a written personal plan. Information was in an accessible format, with for example, a resident's personal preferences were displayed in pictorial format. Personal plans were individualised and person-centred and contained information such as key people in the resident's life, special events, favourite outings or places and a range of likes and dislikes. The inspector noted that a priority for the acting CNMII and the newly appointed Activities Coordinator had been to support residents to engage in meaningful activities during their day and it was observed that this had commenced with the potential to greatly improve the quality of life for residents in this centre. Each resident had a timetable that outlined what he or she did on a daily and weekly basis. Information included both day services and activities that the resident participates in and enjoys. However, some improvements were required to personal plans to ensure that they fully met the requirements of the regulations, in particular in relation to the setting of residents' personal goals as it was not clear how goals contributed to improving residents' quality of life. In addition, the review of the personal plans, in particular goals for residents' lives was not multidisciplinary, as required by the Regulations and future planning was not always evidenced in the personal plans. These issues around the person centred planning had been identified by the Cope Foundation service in its annual review of the quality and safety of care in the centre that had been completed in November 2017.

Regulation 5: Individual assessment and personal plan

The designated centre did not meet the assessed needs of all residents as there was an unsuitable mix of residents in the centre.

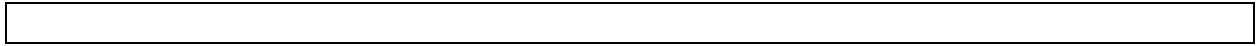
Some improvement was also required to the personal planning process.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Improvement was required to ensure that restrictions were being applied in accordance with policy and evidence based practice.

Judgment: Not compliant



Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Cork City North 18 OSV-0005628

Inspection ID: MON-0023725

Date of inspection: 26/02/2018

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>The annually MDT review for each resident was held on 27/4/18. Following this review the PIC has submitted referral to relevant MDT member whom are required to assess and identify effective plan appropriate to residents needs and wishes. Each resident has a key worker identified to them the PIC will ensure all personal support plans are reviewed and updated to reflect the residents needs and personal goals.</p> <p>The activation staff have developed personal plans to support residents to engage in meaningful activities both onsite and external to the centre.</p> <p>Family forum was held on 10/05/2018 and will continue to be scheduled 6 monthly.</p> <p>The PIC has developed a schedule to ensure PCP's are reviewed with the residents and their families throughout the year.</p>	
Regulation 7: Positive behavioral support	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioral support:</p> <p>A training schedule is in place to ensure all staff have received training/refresher training in [intervention and de-escalation techniques]. All staff on site have received training in safeguarding vulnerable adults and plan is in place for staff returning from maternity leave to attend the training.</p> <p>The PIC has arranged for the positive behavioral team to deliver positive behavior</p>	

support programme to staff. The CNS in behaviour is developing behavioral support plans for relevant residents in conjunction with the resident and staff supporting the resident.

The PIC oversees Bi monthly safety meeting within the centre to monitor and review incidents. Monthly review meetings are also held with the safeguarding designated officer and the governance structure within the centre these meeting include monitoring of interim safeguarding plans and any peer to peer incidents. The Provider will liaise with the PIC and designated officer with progress update regarding transition for one resident to alternative suitable residential setting.

The PIC has reviewed the restrictive practice log and completed risk assessments as per the organization policy. The prescribing of PRN medication for the relieve of agitation (for specific resident) was reviewed and discontinued. Where restrictive practices were used/impacted on residents the PIC and Key workers have updated the residents support plan to reflect use of same and to ensure review timeframes are met.

The PIC and PPIM will ensure the restrictive practice committee will carry out an unannounced audit of restrictive practices used to ensure the procedure is in line with the organization policy.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	01/10/2018
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's	Substantially Compliant	Yellow	4/06/2018

	wishes, age and the nature of his or her disability.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	14/05/2018
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	01/09/2018