Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Cork City North 19
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	30 August 2018
Centre ID:	OSV-0005629
Fieldwork ID:	MON-0024693

About the designated centre

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

Cork City North 19 is a a ten bedded bungalow located on the outskirts of Cork City and run by the COPE Foundation. The house is part of a shared campus with six other houses. Residents are adult male and female presenting with varying levels of intellectual disability, high support needs and complex healthcare needs. The house is fully accessible with free access to communal areas. The accommodation comprises two day rooms, a kitchen and utility room, a dining room, a therapy room, two bathrooms, a shower room, a laundry, a staff office, four single bedrooms - one of which is en-suite. There are three shared bedrooms.

The following information outlines some additional data on this centre.

Current registration end date:	03/09/2020
Number of residents on the date of inspection:	10

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
30 August 2018	07:30hrs to 17:00hrs	Michael O'Sullivan	Lead

Views of people who use the service

The inspector met with all ten residents on the day of inspection. Many residents had little or no verbal communication. Throughout the inspection, residents appeared comfortable and relaxed with all support provided by staff. Staff addressed residents in a respectful manner. Care was offered in a timely and dignified manner.

Capacity and capability

The provider did not ensure effective governance and management arrangements to ensure residents received a good quality of care and support in accordance with their assessed needs and wishes. Improvements were required by the provider to ensure that the effectiveness of all aspects of the service provided were reviewed and documented.

A number of residents required one-to-one direct supervision and care as a result of their level of dependency, vulnerability and high physical and medical needs.There was documentary evidence that over a six month period rostered numbers of staff by day in the designated centre ranged from three to five staff members. On a number of occasions, rostered staff were redeployed to other houses. On the day of inspection the roster had four staff named, which included one member of staff who was to work in another house. There were two student nurses also present in the centre - one fourth year student as part of the staffing complement and one second year student who were both actively engaged in resident care. At times, gaps in the staff roster were filled by the person participating in management.

A member of staff who was listed and classified in an activation role, was specifically employed to attend to the centre's laundry and had no role in activation of residents. Another member of staff listed in an activation role was no longer in post, having accepted a promotion in another designated centre since July 2018. Activities documented as activation were in fact risk and falls assessments conducted by staff.

The statement of purpose dated March 2018 reflected fourteen staff allocated across the working week - three by night and four by day. The minutes of a staff meeting conducted in June 2018 recorded that the staffing complement was four staff including the staff member attached to the laundry service. Staffing levels were at a lower level to that of the last inspection in July 2017. The inspector found that the provider did not have the number and skill mix of staff appropriate to the number and assessed needs of the residents in place.

The statement of purpose available to staff and residents was dated April 2017 and

referenced the previous person in charge. A copy, made available to the inspector, was dated March 2018. It did not contain any specific therapeutic techniques used in the designated centre and arrangements made for their supervision. Staff indicated that a family forum was facilitated in May 2018; however, there was no evidence available to the inspector that this had occurred and what actions arose from it. This forum was not detailed in the statement of purpose. The fire precautions and associated emergency procedures for the centre were not detailed in the statement of purpose.

A resident who had transferred from another house into the designated centre had no record of the transfer reflected in their records. The directory of residents was not updated to include this person. There was no indication that the resident or their family had been informed of the transfer. Many notices, documents and care plans referenced the previous person in charge who had left the service in 2017.

There was little evidence to the inspector that deficiencies identified by the registered provider through annual reviews and six-monthly audits had resulted in any action taking place. There was no evidence that such reviews were made available to residents and their families. Of the sixteen actions identified in the six-monthly report dated April 2018, only part of one action was in progress. While it was acknowledged on the day of inspection that staff had raised concerns verbally in relation to the quality and safety of care and support provided to residents, there was no record of these concerns or how the provider proposed to address them.

The person in charge had given the chief inspector notice in writing of all adverse incidents within the designated centre.

Regulation 15: Staffing

The inspector was not assured that the provider had in place the number and skill mix of staff appropriate to the number and assessed needs of the residents.

Judgment: Not compliant

Regulation 19: Directory of residents

A resident who was transferred into the designated centre was not entered in to the directory of residents

Judgment: Not compliant

Regulation 21: Records

Records in relation to each resident were inconsistent and not subject to regular review, were separated across many folders, clipboards and files which made it difficult to retrieve and understand.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider failed to ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. Six-monthly reviews undertaken by the registered provider in April 2018 and June 2018 had many adverse findings documented with no action taken. Staff concerns relating to the quality and safety of care and support provided to residents was not documented.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared in writing a statement of purpose that did not contain all of the information as set out in schedule 1.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had given the chief inspector notice in writing of all adverse incidents within the designated centre.

Judgment: Compliant

Quality and safety

The design and layout of the centre was suitable for meeting the needs of residents. The centre was clean, comfortable and well maintained. It was evident to the inspector that the residents were in receipt of nursing and physical care support that met their needs at a basic level.

One resident who had significant needs and vulnerabilities required the use of a walker to mobilise; however, the walker had not been in use for three weeks while awaiting repairs from the providers occupational therapy service. The repairs were completed on the day of inspection, at the inspectors request.

Only three of the ten residents attended the day service facility on the campus. There was no evidence documented in the residents' care plans that captured what their involvement in the day service entailed. Significant improvement was needed in person centred planning. Basic short term goals identified in residents' care plans had neither been achieved nor subject to review. Residents had less supports to develop and maintain links with the wider community than they had on the previous inspection. Resident access to occupation and recreational facilities within the centre was limited by roster shortages and unfilled posts. There was no evidence that the quality of care and service provision was subject to monitoring within the centre.

There was little evidence that individual assessments and personal care plans for each resident reflected their current needs. Matters of change of circumstance, deterioration or hospitalisation were not included in the residents' care plans. While an annual review had been carried out, not all multidisciplinary team members attended for residents with significant physical and healthcare needs. Internal waiting times for residents requiring multidisciplinary input ranged from six weeks to six months.

The risk register for the centre was last updated in July 2017. The named person responsible for the risk had left the service in 2017. Hazards identified were not linked back to the residents' care plans. Resident's who had returned from hospital after incidents of falls, aspiration pneumonia or respiratory tract infections had no update in their individual care plans and were not subject to review by occupation therapy and speech and language therapy staff. The risk register was out of date, unsigned and had no follow up actions recorded.

The registered provider had taken adequate precautions against the risk of fire and evacuation drill times had improved significantly from eight minutes to three minutes. However; residents' personal emergency evacuation plans were not updated, nor did they have a review date. One resident, who had recently transferred into the centre, still had an evacuation plan that related to their former residence. The fire notice on the centre notice board was generic and advised residents not to use the lift.

The provider had a restrictive practices log in place which had not been updated since May 2017. Any resident who was subject to a behavioural support plan had a restrictive practice recorded in the log; however, environmental restrictive practices that were applied to all residents were not recorded. There was little evidence that restrictive practices had been subject to occupational therapy review - a decision

was recorded at one staff meeting that bed rails were to be applied to one residents' bed. There was no subsequent assessment or entry in the residents' care plan. A resident who depended on a strap in walker to mobilise was not considered subject to a restrictive practice. Staff did not record the length of time that the resident spent in the walker. The inspector found that restrictive practices within the centre were not subject to appropriate oversight and review.

Regulation 13: General welfare and development

The registered provider failed to provide each resident with appropriate care and support having regard to the nature and extent of the resident's disability and assessed needs and their wishes.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider did not ensure that there were systems in place in the designated centre for the assessment, management and ongoing review of risk.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had systems in place to effectively manage fire and safety; however, personal emergency evacuation plans required updating.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge did not ensure that residents' personal plans were the subject of review.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The registered provider failed to ensure that therapeutic interventions were implemented with the informed consent of each resident, their representatives and reviewed as part of the personal planning process.

Judgment: Not compliant

Regulation 17: Premises

The registered provider ensured that the premises met the objectives of the service and the number and needs of the residents. However, the provider had failed to ensure that repairs to equipment in use in the centre were completed at quickly as possible to minimise disruption to residents.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 17: Premises	Substantially compliant

Compliance Plan for Cork City North 19 OSV-0005629

Inspection ID: MON-0024693

Date of inspection: 30/08/2018

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered provider has commenced recruitment process to fill identified skill mix gaps within the centre to meet resident's needs. The PIC has amended the roster documentation so that it clearly states the grade of each person assigned to the designated centre on a daily basis. The PIC and registered provider will review the statement of purpose to ensure it reflects the number and skill mix of staff appropriate to meet the needs of the residents and compliant with schedule1	
Regulation 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The PIC has updated the directory of residents to include the transfer of new resident.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The PIC has developed a schedule to review and update all residents support plans.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Registered provider has identified a person to support the PIC on a short term basis. This support person will provide leadership and management advice and support to the	

PIC. The PIC will review six monthly reports and develop appropriate action plans for the findings within the reports. The findings and actions of the six monthly reviews will be communicated with the staff supporting the residents. The quality and risk team have scheduled a planned unannounced review of the centre. Residents and their family representatives will be consulted by the team prior to the review. Evidence of this consultation will be documented in the review report.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The registered provider will review the SOP to ensure it is compliant with schedule 1 and will ensure an accurate most up to date version is available to resident/staff and family representatives.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

The registered provider will ensure an activation coordinator is appointed to the centre (15/10/2018) The PIC will liaise with the day service to ensure records are kept and communicated with the centre to capture residents involvement and progress. The PIC will ensure all residents have PCP carried out to capture their wishes and interests and complete PALS assessment to support residents to access recreational activities and maintain links within their communities. Individuals goals will be identified for each resident and reviewed on regular basis. Training has been organised for staff to undertake in support planning and goal setting.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The PIC has reviewed and updated the risk register. The PIC will review the risk register on a regular basis and discuss the management and on -going review with PPIM. The PIC will include individual risks when updating individual support plans.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The Register provider will ensure all residents Personal emergency evacuation plans are updated to reflect support the resident will require in the event of fire and ensure regular review of same to capture any changing needs and support residents in procedures to follow in the event of fire. The PIC has reviewed the fire notice displayed within the centre

and replaced the notice containing information relevant to the centre evacuation procedures.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

The PIC has developed a schedule to review and update all residents support plan and personal emergency evacuation. plans. The PIC has updated health action plans for a resident who has been recently discharged from hospital. The registered provider has requested a multidisciplinary review for residents within the centre to assess and develop individual plans which will reflect residents changing needs and capture their interests and wishes. The registered provider has planned training for staff in support planning and goal setting.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The PIC is liaising with the Positive behaviour support team to review /develop individual interventions. Two staff from the Positive behaviour support team have been booked on training to enable greater deliver of MAPA training. A training matrix is in place to ensure staff are trained and updated in management of behaviours and de-escalation of behaviours. In the event restrictive practices are used within the centre the PIC will ensure these practices are documented within the restrictive practice log and are reflected within individual support plans if the person is affected by the use of restrictive practices. The PIC will ensure where restrictive practices are used that clear records are kept to document the type of restrictive practice, duration and outcome. The Registered provider will arrange for an external person to carry out audit of restrictive practices within the centre. The findings from this audit will be communicated with the staff supporting the residents.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered provider has put in place a process to report any repairs or replacement of equipment or facilities. In the event these repairs or replacement do not occur in a timely manner so as to minimise disruption and inconvenience to residents. A process is in place to escalate such matters to identified personal within the multidisciplinary team. There is regularly planned servicing of specific equipment such as fire equipment and manual and over head hoists and other medical devices and records of such servicing are held on site

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	31/12/2018
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	31/10/2018
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in	Not Compliant	Orange	31/10/2018

	activities in accordance with their interests, capacities and developmental needs.			
Regulation 15(1)	The registered provider shall 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.	Not Compliant	Orange	13/10/2018
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Not Compliant	Orange	13/10/2018
Regulation 19(1)	The registered provider shall establish and maintain a directory of	Not Compliant	Orange	7/9/2018

	residents in the designated centre.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/12/2018
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	13/10/2018
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	1/10/2018
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in	Not Compliant	Orange	14/11/2018

	accordance with standards.			
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Yellow	31/12/2018
Regulation 23(1)(f)	The registered provider shall ensure that that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Not Compliant	Yellow	30/11/2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/11/2018
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the	Substantially Compliant	Yellow	31/10/2018

	procedure to be followed in the case of fire.			
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Substantially Compliant	Yellow	31/08/2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	7/10/2018
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/12/2018
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	Not Compliant	Orange	30/11/2018

	is a change in needs or circumstances, which review shall be multidisciplinary.			
Regulation 05(6)(b)	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 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.	Not Compliant	Orange	31/12/2018
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Not Compliant	Orange	31/12/2018
Regulation 05(6)(d)	The person in charge shall	Not Compliant	Orange	30/11/2018

	ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	31/12/2018
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	31/12/2018
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each	Not Compliant	Orange	31/12/2018

	resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	31/10/2018