Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003698
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Bernadette O'Sullivan
Lead inspector:	Mary O'Mahony
Support inspector(s):	Aoife Fleming;Liam Strahan;;Noelle Neville;Shane Grogan;Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	32
Number of vacancies on the date of inspection:	4

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:	To:
01 September 2015 08:00	01 September 2015 18:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The Health Information and Quality Authority's (HIQA or the Authority) unannounced inspection was undertaken to follow up on the submission by the provider, following a notice of proposal to refuse and cancel this centre's registration. The Authority had issued a written notice of proposal to refuse and cancel registration of the centre following significant failings identified in a number of previous inspections including the most recent unannounced inspection on the 3 June 2015.

The centre consisted of eight houses with a maximum capacity for 41 residents. During this inspection, inspectors met with residents, relatives, staff members and management staff. Inspectors met with the nominated provider to discuss the response to the above proposal and to review implementation of the proposed actions.

The premises and documentation were reviewed by inspectors and care practices

were observed. Due to their complex needs many residents required a high degree of support and assistance with their activities of daily living and individual care. Inspectors found that a number of changes had been made to enhance the quality of life of residents and comprehensive and detailed documentation was viewed by inspectors to support this improvement. This particularly applied to residents who exhibited behaviours that challenge. Individualised positive behaviour support care plans had been developed to support these residents. In addition, training for staff had focused on understanding the reason for the behaviour and on promoting de-escalation techniques. Incidents of alleged peer abuse had decreased and the person in charge stated that a number of residents, who were non compatible, were now living in separate settings.

Overall, inspectors found that there were significant improvements from previous inspections, with an adequate level of compliance with Regulations. The quality of residents' lives had been improved by the provision of dedicated activation staff in each house. Associated documentation was reviewed which indicated that individualised plans were being developed for each resident.

Staffing levels had been increased since the previous inspections. However, an unsolicited receipt of information had been received by the Authority, before this inspection, in relation to low staffing levels. In addition, even though the management team had been augmented since the previous inspection, this had not been maintained on a daily basis. For example, the provider and the person in charge informed inspectors that the new clinical nurse managers, who had been assigned to augment the management team, were required also to fill in for nurse vacancies, in the houses. This resulted in an immediate action plan being issued to the provider in relation to the number and skill mix of staff on duty on a daily basis. Furthermore, the person in charge was requested to provide a copy of the roster to inspectors, on a weekly basis, for a period of one month. A satisfactory response to the immediate action plan was received, within the timeframe set out by the Authority.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Complaints were still not being recorded accurately and in compliance with Regulations.

During this inspection, inspectors reviewed documentation which indicated that residents were consulted with, and participated in, decisions about their care, through advocates and representatives, where necessary.

There was a noticeable change in the compatibility of residents within houses since the last inspection. Transition plans had been implemented to safeguard residents' privacy and dignity. There was evidence that residents and their representatives, where appropriate, had been consulted on decisions about new care settings.

The dignity of residents, who exhibited behaviours that challenge, was protected. Privacy screens were used when necessary. There was a consistent effort from staff to protect the safety, privacy and dignity of residents from certain behaviours, exhibited by other residents. Residents were seen to have comprehensive positive behavioural support plans in place, to guide staff in the appropriate management of behaviour incidents.

During the inspection, inspectors noted meaningful, person centred and structured activity timetables for residents, which met their interests and fulfilled their goals. Residents were observed by inspectors spending periods of time engaged with the activity personnel and other staff, in outside walks, attending the activation centre and engaged in one to one tasks. Inspectors spoke with staff who were now engaged in an

activation role. These staff now had job descriptions and clear guidelines on the responsibilities of the role.

Staff in the centre were being trained in advocacy for residents. External advocacy services were now in place and information days had been held for staff and some residents. Documentation, reviewed by inspectors, indicated that there was an advocacy committee in place.

Complaints records were viewed by inspectors and a number of complaints were documented since the last inspection. These records were now available in each house. However, staff were still using the complaints book to log deficits in equipment such as, complaints about the new medication trolley and the fire alarm malfunctioning. This was discussed with the person in charge who indicated that other complaints were recorded in a centralised log. Appropriate staff training in recording and responding to complaints had yet to be provided and the record of complaints was not easily accessible. Minutes of a recent staff meeting indicated that staff had been informed to make entries in the complaints book, no matter how small. However, there was no evidence available in any of the houses to indicate that this was happening.

Judgment:
Non Compliant - Moderate

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

Findings:
Inspectors reviewed a sample of communication care plans for residents. These were found to be very detailed and personalised. There was pictorial input and lists of verbal and physical touch cues, to aid staff in communicating with residents who had verbal, vision or hearing challenges. For example, inspectors noted that one resident had been swimming, had a foot spa, had family visits, engaged in karaoke, went for walks outside and was facilitated to get a takeaway meal, on a weekly basis.

The use of Picture Exchange Communication Systems (PECS) in the centre was seen to be supportive of residents' communication needs and to be utilised on a regular basis. The centre was part of the local community and residents had access to TV, radio, DVDs and internet, where appropriate. Residents were facilitated to use assistive devises where required, to promote their full capabilities. External professionals such as the National Council for the Blind of Ireland (NCBI) were consulted for input, where

required. A number of staff had been trained in communication interventions and this training was being made available to other staff. Input from the speech and language therapist (SALT) and the dentist was seen in the personal care plans (PCPs) of residents.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that residents were supported to maintain links with their families. Families and representatives visited regularly. A number of residents went home for overnight stays. Inspectors noted records of residents' phone calls with families and that staff contacted family members when necessary. Documentation supporting this was maintained in the residents' personal care plans (PCPs). A visitors' room was now available in each house. Families and representatives were kept informed about their relative's wellbeing and this was confirmed with inspectors, by relatives. There were no restrictions on visiting times except when requested by a resident or when the visit was deemed to pose a risk. Documentation reviewed indicated that families and residents' representatives were seen to attend PCP meetings, in accordance with the wishes of the resident.

Judgment:
Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Documentation in all care plans had not yet been updated since the previous inspection.

During this inspection, inspectors reviewed a sample of residents' PCPs and observed residents' daily routine. All residents had a detailed health check which assessed residents' health care needs. A comprehensive assessment of residents social care needs had been conducted for all residents. Evidence of multi-disciplinary input into residents' personal plans was seen by inspectors. From speaking with residents and staff and following a review of documentation, inspectors formed the view that activities provided for residents were based on their interests and preference. There were documentation and minutes of meetings available to support the provision of activities and the success or otherwise of the particular activity. Since the previous inspection in June 2015, the social care needs of residents had been addressed in a person centred manner. Inspectors saw evidence of improved outcomes for residents. For example, there were less incidents of behaviours that challenged and less incidents of peer on peer aggression.

The provider informed inspectors that the activation staff now had specific job descriptions. They received guidance and supervision from management staff. Minutes of these meetings were viewed by inspectors. Staff informed inspectors that residents access to external activities, for example, going swimming, going walking, shopping or out for meals, was now more likely to occur due to the increased availability of staff and transport. The provider informed inspectors that health services executive (HSE) funding had been made available and private taxis were now available for residents' use, if a minibus could not be accessed.

Since the previous inspection, residents who were identified as requiring alternative placement had been relocated to other more suitable living arrangements. Inspectors viewed assessments of compatibility which had been undertaken by a behaviour specialist. The nominated provider informed inspectors that transition plans were detailed and were planned in partnership with residents and their representatives. Inspectors viewed documentation and copies of transition plans which confirmed this.

There was a new documentation suite available for each care plan. A considerable amount of work had been carried out by the clinical nurse manager (CNM) and the management staff since the previous inspection on improving documentation and associated training for staff. However, the PCP of one resident who had specific needs had yet to be updated. This resident's documentation was not easily retrievable and there were gaps in documentation seen by inspectors, which were highlighted on previous inspections. New documentation, related to this PCP, was forwarded to the Authority following the inspection.

Judgment:
Substantially Compliant

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
Inspectors found that the premises were generally kept in good repair internally and externally. The enclosed gardens and courtyards of several houses were now safe to access. A grab rail and tiling beside a toilet were now securely attached and all areas of the premises were clean and suitably decorated. Inspectors observed that the kitchens were seen to be clean and a cleaning schedule was on display. New kitchen appliances had been installed, where required. Assistive appliances had been installed in baths and toilet areas.

The suction machines had been repaired and each house now had access to a suction machine, if required. Maintenance issues were now addressed promptly. Inspectors observed maintenance personnel attending to repairs while they were on the premises. Chemical and laundry rooms were locked and furniture was in good repair.

In one house inspectors found the external grounds area had been upgraded. However, part of the premises required redecoration and upgrade. For example, the walls and shelves required painting and bathroom tiles were noticed to have been removed and not replaced. In addition, some external areas remained uneven and presented a falls risk. This was discussed with the person in charge and the provider. The provider stated that a decision had been taken to apply for this house to be registered as a separate entity.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
The 'sharps' bin, used for the disposal of needles and syringes, was not stored securely. This was similar to findings on previous inspections.

On this inspection, inspectors found that most of the actions identified in the previous inspection had been addressed. The centre had implemented a robust system to identify, assess, manage and review risk on an on-going basis in the centre. The majority of risks identified on the previous inspection had been mitigated or minimised. A copy of the risk register was viewed by inspectors. This was a new updated register according to the CNM, and a copy was to be printed for each house.

A kitchen cleaning schedule had been commenced in each house since the last inspection. Staff informed inspectors that these cleaning duties were now carried out by a dedicated team of cleaning staff. Inspectors observed that the kitchens in each house were cleaned to a high standard.

Inspectors noted however, that a sharps bin was still stored in a press, in the office of one house, and it had to be moved each time residents' medical files needed to be accessed. This posed a risk of needle stick injury and cross-contamination. The person in charge stated that staff had been instructed to keep this 'sharps' bin locked in a secure place.

Since the previous inspection suction machines, for use by staff in the event of a resident choking or other emergency, were repaired and the person in charge stated that there were extra machines now available, if required. Transport buses had been serviced and worn tyres had been repaired. Detailed and personalised risk assessments were now in place for residents who wished to go swimming. These risk assessments were seen by inspectors to be based on the medical and social needs of residents.

There was documentary evidence that the provider had put in place a centre-specific risk policy dated 11 May 2015 which included the specific risks identified in the Regulations. Inspectors spoke with staff about the incident reporting and management system. They were aware of the process involved and stated that the CNM reviewed incidents in conjunction with the provider and the person in charge. This review contributed to improvements in residents' safety in the centre and was discussed at staff meetings. Minutes of these meetings were made available to inspectors.

Inspectors reviewed the fire safety register in the centre and found that there was evidence of regular fire drills being conducted. Fire alarm systems were tested on a regular basis and daily inspections of fire escape routes were conducted by staff in the houses. Fire safety training had recently been provided for many staff members. Individualised personal emergency evacuation plans had been developed for all residents and fire training had been undertaken by all staff. Inspectors viewed evidence

of good communication between the person in charge and the provider, on health and safety issues. Email communication, from the provider to the person in charge, seeking clarification on notifications and incident follow up were seen by inspectors.

Judgment:
Substantially Compliant

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

Findings:
Inspectors spoke with the person on charge and the provider in relation to safeguarding residents from abuse in the centre. This included alleged verbal abuse incidents, by staff towards residents, which were witnessed by inspectors, on both previous inspections in March 2015 and June 2015.

Staff training on safeguarding had been provided to all staff, since the previous inspection. Documentation was viewed by inspectors which indicated that staff had been trained in reporting and recognising abusive interactions. A number of these notifications were received by the Authority. These had been appropriately investigated and where investigations were ongoing the provider had supplied updated information, when required. The CNM had developed a new process to enable staff to improve their recording and documentation of incidents. This was viewed by inspectors and was titled the 'Threshold Guide'. Staff were familiar with this process and its use was noted by inspectors, when notifications were received by the Authority.

Positive behavioural support plans were seen in residents' PCPs. These were detailed and individualised and staff were noted to be knowledgeable of these. The clinical nurse specialist (CNS) in behaviour issues was spoken with by inspectors. He explained the training programme provided to staff members. He stated that training was aimed at changing staff attitude towards behaviour that challenged. Institutionalised or a routine approach to residents' care needs was discouraged and support plans were put in place to identify and alleviate the cause of, and triggers for, residents' behaviours. Inspectors noted that the quality of life of residents with high support needs had improved as a result of this approach.

Inspectors reviewed practices in the use of restraint in the centre. Several actions had been identified in the last inspection regarding the use of restraint. However, these were now addressed in line with national guidelines and best practice. Inspectors viewed documentation which confirmed that the use of certain restraints seen on previous inspections, for example, a groin restraint, was discontinued. Practices in the use of bed-rails in the centre had been strengthened since the previous inspection. For example, a day-time, as well as night-time, review and release checklist was implemented and the regulatory restraint log was maintained. Physical restraint had been discontinued for certain residents where, because of their physical size and stature, they had been risk assessed as not suitable for the physical intervention. This approach indicated to inspectors, that each resident was now risk assessed individually, before any form of restraint was employed.

However, inspectors noted that there was inadequate documentation in the PCP of a resident who was noticed to have bruises. There was a safeguarding plan in place for this resident however, the documentation viewed by inspectors lacked detail and was not a comprehensive record. This was similar to documentation which was in place during the previous inspection. The CNM2 stated that this PCP would be updated. Satisfactory documentation was forwarded to the Authority following the inspection.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
Notifications were made to the Authority in a timely manner in line with Regulations.

The person in charged was asked to audit NF06 notifications as the allegations of peer abuse required to be addressed.
NF07 and NF06 forms received, indicating alleged staff misconduct in relation to interactions with residents, were still under investigation by the centre.

The person in charge stated that a follow up would be sent to the Authority, when available.

Judgment:
Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
All healthcare needs were not responded to in a timely manner.

Inspectors reviewed a sample of residents' personal plans. Documentation was viewed which indicated that residents received appropriate healthcare from specialists and allied health professional, where required.

Since the last inspection, the system for the daily handover of information between staff at each shift change had improved. There was continuity of staff in the houses and more comprehensive and robust documentation and care planning methods had been implemented.

Residents' had their weight monitored and documented in their personal plans and the MUST (Malnutrition Universal Screening) tool was used to calculate residents' nutritional status. Residents who had experienced weight loss were referred to a dietician for assessment. Input from the dietician was evident from documentation reviewed. Residents were prescribed nutritional supplements where required and these prescriptions were viewed by inspectors.

Staff and management informed inspectors that access to allied health care professional services had increased since the previous inspection. For example, the speech and language therapist (SALT) had provided care plans for residents with dysphagia (difficulty swallowing). Staff had received training in modified diets from a nutrition company. Residents with impaired mobility had been reviewed by the occupational therapist (OT) and physiotherapist.

However, one resident who was prescribed anti-epileptic medications and had been reviewed by the general practitioner (GP) following a recent seizure, did not have relevant blood levels checked. This had been indicated as required, by the GP. This was similar to findings on the previous inspection.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents, Individual medication plans were appropriately reviewed and put in place, as part of the individual personal plans. The processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation. Staff followed appropriate medication management practices. There were appropriate procedures for handling and disposing of unused and out-of-date medicines. A system was in place for reviewing and monitoring safe medication management practices. Residents had access to a pharmacist of their choice or one that was acceptable to them. The person in charge gave appropriate support to the resident in his/her dealings with the pharmacist (if required).

However, there were gaps in the maintenance of documentation in relation to the policy on PRN (when necessary) medication. For example, the protocol for the administration of PRN medication was not robust and alternative measures were not recorded prior to the administration of a PRN medication. In addition, the effect of the administration of PRN medication was not recorded.

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

Findings:
The centre had a full time person in charge and the nominated provider had been involved in the centre on a daily basis, in response to regulatory findings. There were regular unannounced visits by members of the management team. The CNM regularly collated and audited incidents and accidents in each house. The actions arising from these reports were seen to inform practice improvement. For example, the centre was noticed to be very clean on this inspection and the risk register had been populated with relevant risk assessments. Controls in place to mitigate or minimise risks were seen to be realistic and achievable. The quality and content of residents' personal plans were now assessed by the provider nominee or person in charge. There was an annual assessment of the safety and quality of care and support undertaken in the centre. This was viewed by inspectors.

Inspectors reviewed the minutes of staff and management meetings. These indicated that concerns and incidents were discussed and regulatory issues formed part of the discussion. Staff reported to inspectors that guidance and assistance from management was supportive. The activation staff now had clear job descriptions and their role had been outlined to them in weekly meetings with management. Minutes of these meetings were viewed by inspectors. Staff showed inspectors the individual activation plans for residents and they explained how the plans were meaningful and were related to fulfilling residents' goals

Inspectors formed the view that the governance and management of the centre had been strengthened and this had a significant positive impact on the safety, welfare and quality of care for residents. However, inspectors were informed that the clinical nurse managers would be rostered to work in the houses, if a staff nurse was not available. The provider and person in charge agreed that this arrangement impacted negatively on the effectiveness of the team. This was significant as lack of staff supervision, as required under Regulation 23 (3), was highlighted by inspectors, on previous inspections. This system of depleting the management team to fulfil other roles was not sustainable in the centre, in view of the significant and serious governance and management issues found on previous inspections. The provider was asked to review the skill mix and qualifications of staff required in the centre. Staffing issues were addressed under Outcome 17: Workforce.

Judgment:
Non Compliant - Moderate

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
Inspectors noted that more resources had been provided to support the staffing requirements of the service, to ensure the delivery of safe and effective care to all. Training had been provided to staff and increased staffing levels had been sanctioned for the centre. However, staff shortages remained an issue at the time of this inspection and the provider was issued with an immediate action plan on staff numbers and skill mix as identified under outcome 14: Governance and management.

The lack of availability of transport had been addressed. Private taxis had now been commissioned for use, when a minibus was not available. However, during this inspection, inspectors noted that a resident had not been facilitated to go on his usual bus outing, due to the unavailability of a driver. This was addressed while inspectors were on the premises and alternative arrangements were made for the resident to go out for a drive with staff. The person in charge stated that more staff drivers would be recruited and that resources would be regularly reviewed, to prevent a reoccurrence of similar issues.

Repair and maintenance issues highlighted to and by inspectors during the last inspection had been addressed.

Judgment:
Substantially Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Staffing availability, to replace staff on annual leave and on sick leave, had yet to be fully addressed.

Inspectors were assured that the overall supervision and training of staff in the centre had improved since the last inspection. This view was formed staff interviews, staff appraisal forms and training records reviewed. Staffing levels had increased and staff recruitment was continuing. However, as discussed under Outcome 14: Governance and management, management staff were regularly deployed from their management duties to cover the absence or shortage of other staff members. The provider and person in charge stated that there were occasions when staff were not available to replace those staff on sick leave or on annual leave. Where staff were absent on sick leave or on holidays contingency plans had not been put in place for these eventualities. Staff, spoken with by inspectors confirmed this and inspectors viewed relevant rosters. An immediate action plan was issued to the provider on the number, skill mix and qualifications of staff in the centre. A satisfactory response was received by the Authority, within the timeline specified by the Authority.

Regular staff training sessions had been conducted since the last inspection. Staff had completed training relevant to their role in the centre. Staff supporting residents with behaviours that challenged informed inspectors that they had been provided with relevant training, to enable them to interact positively with these residents. Fire safety training and manual handling training documentation indicated that staff training was up to date. The CNM had provided training to staff on safeguarding and protection of vulnerable residents and new documentation and strategies had been developed to support this training. Copies of the documentation were viewed by inspectors. Staff with whom inspectors spoke demonstrated knowledge of the new strategies. In addition, notifications from the centre, received by the Authority since this inspection, were seen to reference the new documentation.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Complete records were maintained in the centre. Records that were viewed by inspectors were accurate and up to date. Residents had access to their PCPs where required and records were seen to be stored securely. New documentation had been in developed and the positive behavioural support documentation and health assessments seen were detailed and person centred.

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 were maintained in a manner to ensure completeness, accuracy and ease of retrieval. The designated centre was adequately insured against accidents or injury to residents, staff and visitors.

Records relating to inspections by other organisations were maintained and there was a comprehensive Resident's Guide available to residents and their representatives.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003698
Date of Inspection:	01 September 2015
Date of response:	20 October 2015

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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An effective complaints procedure for residents in each house was not being maintained as the complaints log was not properly maintained and gaps were seen in the maintenance of documentation. The complaints book was not being utilised in an effective manner.

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

1. Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

Please state the actions you have taken or are planning to take:
•All staff have been made aware of new complaints policy & the importance of using the complaints procedure.
•Algorithms for new complaints policy are clearly on display throughout the Designated Centre.
•Protocols are in place for logging issues of concern and for logging complaints and all staff are aware of same.

Proposed Timescale: 16/10/2015

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:
A resident's personal plan seen by inspectors was not reviewed to reflect a change in needs or circumstances. Gaps were seen in documentation in this PCP which were highlighted on previous inspections.

2. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
•Resident referred to had Person Centred Plan updated on 11/09/2015. New goals were identified and health care plan was updated.
•Safeguarding plan was reviewed and updated on 11/09/2015.

Proposed Timescale: 11/09/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that one house required redecorating and the external grounds of that house required repair.

3. 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:
•Maintenance list was compiled and discussed with organisational facilities Manager.
•This house has since become a separate designated centre under new PIC, officially since 21/09/15, with effective transfer of relevant information including outstanding maintenance issues having taken place.

Proposed Timescale: 21/09/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that residents who may be at risk of a healthcare associated infection were protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.
For example:
-the 'sharps' bin had not been securely stored, thereby presenting a risk of infection and cross contamination.

4. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
•All staff were instructed of the arrangements for safe storage of sharps bins on 02/09/15.
•Clearly designated storage areas for sharps bins were identified with clear signage illustrating same 02/09/2015.

Proposed Timescale: 02/09/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to take appropriate action to investigate bruising sustained by a resident.

5. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
•Safeguarding Plan for relevant resident was reviewed and updated on 11/09/2015 with detailed and comprehensive protocols / guidelines around bruising and protocols regarding documentation and accurate recording of incidents and accidents.

Proposed Timescale: 11/09/2015

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:
The person in charge had not facilitated the medical treatment that was recommended for each resident and agreed by him/her.
For example: a resident hid not have appropriate blood tests carried out, following a seizure, as recommended by the GP.

6. 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:
•Appropriate medical treatment such as blood tests post seizure, will be carried out in a timely manner, as recommended (02/09/15).
•Each resident will have best practice guidelines and timelines for medications which require routine blood monitoring by 31/10/15.
•An easy read version explaining to residents' "why I need a blood test" will be in each resident's personal care plan.

Proposed Timescale: 31/10/2015

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:
The person in charge had not put in place appropriate and suitable practices relating to the administration of PRN medicines to ensure that medicine that was prescribed was administered as prescribed to the resident for whom it is prescribed. Alternative measures to the PRN medication were not recorded and the effect of the medication

was not documented in line with professional guidelines.

7. 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:
•Appropriate guidelines / protocols are now in place to ensure recording of alternative measures prior to administration of PRN medication, as well as recording mechanism for the effect of the medication in line with professional guidelines.

Proposed Timescale: 19/10/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failing to maintain effective arrangements to support, develop and performance manage all members of the workforce, to exercise their personal and professional responsibility, for the quality and safety of the services that they were delivering. Inspectors found that although the management team had been enhanced, members of the management team were assigned to work in the houses, when a rostered member of staff was on sick leave, or when there was a staff shortage. This impacted on staff supervision and staff training duties of the management team.

8. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
•An additional CNM1 has been recruited to enhance the management team and is commencing in post on 09/11/15.
•An additional staff nurse commenced in the designated centre on 03/09/2015. Three additional pre-registration staff nurses commenced in the designated centre on 28/09/2015. These are now staff nurse positions following the completion of registration process on 20/10/15. This has strengthened staff nurse numbers by an additional 4 reducing the necessity for clinical nurse managers to carry out staff nurse duties.
•On 21/09/15 the responsibility for the medication and health needs of a resident in an off-site residential setting was transferred. This setting is now a stand-alone designated centre which no longer comes under the remit of the centre. This has had a positive impact on the management and governance.

•A full review of staff skill mix took place on 04/09/15 and where gaps were identified in skills we will encourage staff through performance management to undertake education and training.

Proposed Timescale: 09/11/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident was not facilitated to go on his usual outing, due to the unavailability of a staff driver.

9. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
•A review of current availability of staff drivers was undertaken by the person in charge on 19/10/15.
•The person in charge will identify other staff members who hold qualifications in relation to the transport policy and add these to the driver database.

Proposed Timescale: 23/10/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.
Where staff were absent on sick leave or on holidays contingency plans had not been put in place for these eventualities.
An immediate action plan was issued to the provider on the number, skill mix and qualifications of staff in the centre.

10. 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:
•Protocols and guidelines were developed on 16/10/15 with regard the taking of annual leave. This has ensured that holiday applications are planned more effectively and contingency plans are in place should staff be absent on sick leave.
•We have strengthened the staffing number within the designated centre by 4 additional staff nurses since 21/09/15.
•An additional CNM1 has been recruited to enhance the management team and is commencing in post on 09/11/15.

Proposed Timescale: 09/11/2015