

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cork City North 4
Centre ID:	OSV-0003698
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Liza Fitzgerald
Lead inspector:	Carol Maricle
Support inspector(s):	Conor Dennehy
Type of inspection	Announced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	3

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 September 2017 10:00	13 September 2017 17:00
14 September 2017 08:00	14 September 2017 13:20

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

Outcome 01: Residents Rights, Dignity and Consultation
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 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

The designated centre offered a residential service to adults with disabilities. This was the second inspection of this centre since it had reconfigured as a standalone centre in 2016. The centre had previously been part of a larger centre in 2014 and 2015.

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

How we gathered our evidence:

As part of the inspection, the inspector met with eight residents and members of the staff team that included nurses, student nurses, care assistants, the person in charge, two persons involved in the day-to-day management of the centre and the person representing the provider. Not all of the residents were able to or opted to share their views verbally with the inspectors about the service provided; however, the inspector spoke with some of the residents' representatives and observed staff

interacting with residents. The inspector reviewed documentation such as a sample of residents' personal plans, pre-inspection questionnaires submitted by the representatives of residents along with other relevant records kept in the centre. A resident asked inspectors not view their file and this was request was respected.

Description of the service:

The provider had produced a document called the statement of purpose, as required by the regulations, which described the service provided. During and immediately following this inspection, the person representing the provider made a number of changes to the statement of purpose to ensure that it accurately reflected the service the centre provided. The centre provided full-time residential accommodation and services to residents that had a diagnosis of an intellectual disability and or diagnosis of autism. The maximum number of residents that the centre could cater for was eighteen and, at the time of this inspection, the centre had three vacancies. The inspectors found that the service was being provided as it was described in the document.

The centre comprised four purpose-built units on a campus style setting on the outskirts of a city. Three units were located close to each other and the fourth was located within the wider campus. The units situated close to each other had each a kitchen, a living room, separate laundry facilities and bedrooms accommodating each resident. These units had more than one communal area and some had visiting rooms. In addition, one of these units contained a single occupancy apartment comprising a sitting room with dining facilities, kitchen, bedroom and bathroom. The remaining unit was a single occupancy apartment located within the wider campus and this contained a kitchen, dining and sitting room area, a bedroom and bathroom.

Overall judgments of our findings:

Overall, it was demonstrated that residents were supported appropriately by staff on a day-to-day basis. There were adequate governance systems in place. However, there were a number of regulations not being complied with. Some areas of non compliances were identified in relation to:

- personal planning arrangements (Outcome 5)
- premises (Outcome 6)
- risk assessments (Outcome 7)
- safeguarding and restrictive practices (Outcome 8)
- notifications to the Health information and Quality Authority (HIQA) (Outcome 9)
- oversight of healthcare management plans (Outcome 11)
- oversight of auditing (Outcome 14)
- supervision systems (Outcome 17)
- records (Outcome 18).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Not all components of this outcome were reviewed as the inspector focused upon actions arising from the previous inspection. These actions included the management of complaints and the issue of incompatibility of residents compromising the dignity of some residents in one unit. At this inspection, the inspectors found that the provider had addressed both actions.

As part of the action plan from the previous inspection, a single occupancy apartment had been created in one of the houses and this facilitated a resident to move there and in a planned manner. An inspector met with a family representative and staff members who expressed satisfaction in how this transition was planned and carried out. This transition was recent, therefore, the impact that this move had on the quality of life of the resident was not yet fully determined.

An inspector viewed the system of complaints within the centre. Staff were guided in the processing of complaints by an organisational policy. Easy-to-read information on complaints was displayed throughout all of the units and this included the name of the complaints officer. There was a separate person nominated by the organisation, other than the nominated person, to whom complaints could be addressed to. Family representatives had an understanding of the system and they told inspectors that they were comfortable raising issues with staff and the management team. Where complaints had been made, representatives confirmed satisfaction with how these were resolved. As part of this inspection, the inspectors met with family representatives of residents living in single occupancy apartments that formed part of this centre. Both family representatives reported that they were satisfied with the care provided to their family

member.

Each of the units that formed part of this centre had a complaints log and this was in hard copy format only. This meant that there was a risk that information may be mislaid; this risk was evidenced and resolved during the inspection. The person in charge confirmed that a computerised version of all complaints made would be created by her to log all complaints going forward.

Overall, there were a small number of complaints received in the 12 months prior to this inspection. Most of the complaints had been closed off at the time of the inspection and the person in charge updated a record to this effect during the inspection. The log book showed how a staff member had on two occasions advocated on behalf of a resident and made complaints on their behalf. The patterns and trends were mainly around the personal items of the residents.

There were appropriate systems in place regarding advocacy. A resident had completed an external course in advocacy at a third level institution. A staff member had recently completed training in advocacy. The management team had met with the newly appointed advocacy officer within the organisation and there were plans in place for the first advocacy meeting to take place at the centre, in conjunction with the newly trained resident and staff member. The person in charge spoke about advocacy services and how they were organising advocates to be appointed individually for residents, where appropriate.

Residents' forums were conducted individually by staff with residents. The records confirmed if the staff member completed the form on behalf of the resident. These forums were conducted monthly in the three months prior to this inspection. A family forum had taken place in 2017 and this showed how families were updated on a wide range of areas, such as the management structure of the centre.

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):

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

Findings:

The organisation had systems in place to ensure that personal planning arrangements were established. The needs of residents were assessed. Personal planning arrangements were subject to review in conjunction with the resident and their representatives. Some of the personal planning arrangements were arranged in an updated format. This meant that some files were significantly easier to navigate and contained relevant up-to-date information. There was insufficient evidence to demonstrate the effectiveness of the planning arrangements for each resident in the year prior to the inspection.

At the previous inspection, a multidisciplinary annual review system was not in place at the centre. At this inspection, this system was found to be in place and all residents had had their needs reviewed in January 2017, following which various actions had been taken such as referrals to relevant services.

As part of the personal planning arrangements, each resident had a set of assessments completed and this included healthcare assessments generally completed by the nursing staff team. Additional assessments were completed (where necessary) in areas such as oral health care, bone health and expression of pain. An inspector found evidence of a healthcare assessment completed by a member of the care team that had not been signed off by a health professional. A person involved in the management of the centre reviewed this assessment and gave assurances to the inspector that these assessments were generally conducted by nursing staff. In this instance, he reviewed the assessment and signed and dated this document. The inspectors found that all other healthcare assessments, viewed by them, were completed by healthcare professionals.

Each resident had personal planning arrangements in place and this set out a range of information about each client, such as, important information for staff to know, important dates in their yearly calendar, their likes and dislikes, their abilities in the area of communication, hospital passports and individualised risk assessments. Each resident had goals created. There were two sets of goals devised, goals devised by the resident following their person-centred planning meeting and other goals devised as part of their personal planning arrangements. All residents had assigned key workers that took the lead on supporting residents to achieve identified goals. The inspectors observed that, at times, there was not an established link between both sets of goals. Furthermore, the way in which goal progression was recorded was not consistent throughout the files.

Some of the residents had a personal plan which was a document all about them, their likes and dislikes and goals they would like to achieve. Families were invited to the establishment and or review of the personal plan and this was called a person-centred planning meeting. At the time of the inspection, not all residents had such a plan developed. Where this was the case, the person in charge demonstrated the date that this plan would be developed. During conversations with family representatives not everyone confirmed their awareness of a person-centred plan. However, they confirmed their involvement in decisions regarding the care and support given to residents and how this was usually done in a formal and informal manner.

The personal planning arrangements for each resident were reviewed by a multidisciplinary team of professionals, employed by the organisation. This was an annual event. The inspector observed that that the multidisciplinary review meeting discussed the physical and social activities requirements of each resident. However, it was not explicit how this review addressed the cognitive and learning ability of each resident and their subsequent ability to attend a day programme, volunteer or to be employed in the community. This issue was also cited in the annual review of the centre.

Judgment:

Substantially Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

This outcome was found to be compliant at the previous inspection. However, there were some findings arising at this inspection regarding one of the single occupancy apartments.

Since the previous inspection, this apartment now required painting and plastering in some areas and external wood features required attention. There was evidence to show that the plastering and painting was due to commence. Following the inspection, HIQA received confirmation that the apartment had been painted and plastered and work was to commence on the exterior of the centre.

There was a malodour present in one of the rooms of the apartment. The management team were aware of this issue and discussed with inspectors attempts to resolve this issue. They committed to bringing it again to the attention of the maintenance team. The hood of an oven required fixing in this apartment. An internal refuse bin required replacement.

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:

Efforts were being made to promote the health and safety of residents, staff and visitors in the designated centre. However, inspectors required assurance regarding the fire safety arrangements in one unit of the centre.

All four units of the centre had fire alarm systems, emergency lighting and fire fighting equipment, including fire extinguishers, in place. Inspectors saw records of certificates of maintenance carried out by external bodies at the required intervals for such equipment. Internal staff fire safety checks were also being carried out and documented but it was observed that there were some gaps relating to weekly checks in this area. A similar finding was also found during the previous inspection.

Fire doors were also present in three units of the centre. However, in the fourth unit inspectors were informed that there were no fire doors installed; there was only one fire escape route provided. As such additional assurance was requested from the provider from a suitably qualified person to determine if adequate fire safety arrangements were in place in this unit.

The previous inspection found that the time taken to evacuate one unit of centre required review due to the evacuation time recorded in a drill in September 2016. At this inspection it was found that subsequent drills in this unit had taken place and the time taken to evacuate had been reduced. Fire drills were being carried out at regular intervals in the other units of the centre also. A record of these drills was maintained but the time of day when the drill took place was not always recorded. This is addressed under Outcome 18.

All residents had a personal evacuation plan (PEPs) in place. While some of these had been recently reviewed and contained relevant information, others were noted not to have been reviewed in over 12 months. In addition in two residents' PEPs, it was observed that the information contained in them did not reflect how the residents might react should an evacuation be necessary or the assistance that was to be provided by staff.

Inspectors queried such matters with staff members who demonstrated a good knowledge of the steps to be followed for these residents should an evacuation be necessary. Training records indicated that all staff had undergone fire safety training but some were overdue refresher training in this area. This is addressed under Outcome 17.

A centre-specific risk register was in place and was noted to have been recently reviewed. The register contained details of risk assessments carried out in relation to issues such as manual handling and slips, trips and falls. Following the provider's most recent annual review of this centre it was noted that the risk ratings applied in the centre-specific risk register had been reviewed to more accurately reflect the actual level of risk within the centre.

Risk assessments relating to individual residents were contained in each resident's personal plan. However it was noted that some assessments had not been reviewed in over 12 months while in others the risk ratings applied required review to ensure that they accurately reflect the actual level of risk. In addition, there were some risks identified by inspectors relating to individual residents which had not been risk assessed. These risk assessments were recorded prior to the conclusion of the inspection.

Systems were in place for the recording of accidents and incidents within the centre. A local risk, safety and audit committee was in place with minutes maintained for three meetings of this committee during 2017. From reviewing these minutes it was noted that adverse incidents and trends were discussed. Staff members spoken with also outlined how they would be aware made of an adverse event and any learning arising. A health and safety statement was also in place which was noted to have been reviewed in November 2016.

The previous inspection found that the centre did not have a site-specific policy to guide and inform staff on the prevention of infection. On this inspection it was found that such a policy had been put in place since November 2016.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

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

Findings:

The organisation had systems in place to residents were protected and kept safe. However, the inspectors found records of allegations of abuse not processed in line with

organisational policy.

At the previous inspection, an action had been given in relation to behavioural support plans and the dignity afforded to a resident. These actions had since been implemented.

The organisation maintained policies on the safeguarding of vulnerable adults and a separate policy on responding to behaviours. The organisation had introduced in 2017 an updated policy on the rights of residents and this addressed the use of restrictive practices. Each resident had an assessment of their ability to self-care and arising from this, an intimate care plan was then created. Family representatives, with whom the inspectors met with confirmed their satisfaction with how their family members were cared for. The questionnaires completed by other family representatives confirmed their satisfaction with the safety of their family members.

Where there were historical concerns of a safeguarding nature open at the time of the inspection the person in charge was seen to be appropriately liaising with the designated officer about the status of these concerns with the relevant statutory bodies.

The person in charge informed inspectors that in the 12 months prior to this inspection there had been no allegations of abuse made by residents. However, an inspector found details of allegations made by a resident and there was no evidence to accompany these allegations to show that due process took place in line with organisational policy. The person in charge immediately attended to this issue and liaised with the designated officer. At the conclusion of the inspection, a review all allegations was due to commence. The person representing the provider provided written assurances to HIQA that all allegations going forward would be processed in line with the organisation's safeguarding policy. At the time of finalising this report, the outcome of the review of all allegations made was not yet concluded.

Inspectors reviewed training records and noted that all staff had been provided with training in safeguarding and de-escalation and intervention. However, some staff members were overdue refresher training in these areas. This is addressed under Outcome 17. During interview, staff confirmed their awareness of safeguarding issues and the persons they would contact should they have concerns in this area.

As part of the multidisciplinary team available to residents, this included access to a behavioural support team. This discipline was also represented at the annual multidisciplinary review meeting of the resident. There was a policy in place to guide staff on how to respond to behaviours. An inspector found reference to records confirming that the quality of life of a resident had improved significantly in the recent months on account of a particular approach being used by staff, in conjunction with the behavioural support team. Each resident, where necessary, had a behavioural support plan that set out to staff how best to respond to behaviours prior to reactive strategies. On occasion, support plans were not sufficiently signed or dated. There had been one use of a particular restrictive practice in the six months prior to this inspection and this incident had been appropriately reviewed by the management team and notified to HIQA.

The inspectors reviewed the use of restrictive practices at this centre. The person in

charge informed the inspectors that all use of restrictive practices had been reviewed in line with the newly updated policy in this area. As part of this review, she identified a small number of restrictive practices which had not been previously notified to HIQA, for example the locking of internal doors such as a kitchen door.

An inspector reviewed the suite of documentation in place for each restrictive practice used. Each practice was subject to a checklist, as devised by the organisation. There was use of bedrails and mechanical devices such as helmets and groin straps. The front door in some of the units was kept locked. The door to the kitchen in some of the units was kept locked. Some of the information in this checklist failed to show how practices were only used following all other methods being exhausted. The person in charge accepted that these practices required further review in order to be in compliance with the organisational policy. A risk assessment pertaining to the use of a kitchen door being locked was factually incorrect as the paperwork mistakenly referred to the external door being locked and not the kitchen door.

The use of visual monitors in two units was put forward by the person in charge as a restrictive practice. The logging of the use of the monitor in one of the units was difficult to understand; the person in charge agreed. The paperwork for both uses was not consistent as a prescriber had recommended its use for one resident but there was no such recommendation on file for the second usage of these monitors. Furthermore, the use of these monitors was not fully set out in the organisational policy on closed circuit televisions (CCTV). This has been commented upon further in Outcome 18.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

There were systems in place to ensure that notifications were submitted to HIQA, in the required timelines. However, there were some gaps.

The person in charge informed inspectors that following a review of all restrictive practices at the centre conducted by a person involved in the management of the centre, a number of practices had been found not have been notified to HIQA each quarter in the 12 months prior to this inspection. She confirmed that having identified this as an issue, it would be resolved immediately.

Judgment:
Substantially 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):

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

Findings:

There were systems in place to ensure that the healthcare needs of residents were identified, assessed and met. However, some improvements were required.

At the previous inspection, residents were found not to have access to psychology services. At this inspection, the person in charge reported to inspectors that no resident was awaiting the services of a psychologist. An action regarding clinical observations and the recording of same had also been addressed.

Residents had access to general practitioners (GPs). They also had access to a multidisciplinary team and this included disciplines such as psychology, behavioural support, physiotherapy and occupational therapy. A consultant psychiatrist visited the campus on certain dates and they could be accessed through this open clinic and also by referral. Residents also had available to them an on-site neurology clinic. The person in charge confirmed to the inspector that the residents frequently attended their GP and records viewed confirmed these arrangements. The inspectors met with some family representatives who all confirmed satisfaction with how the healthcare needs of their family member were attended to. Where there were concerns regarding the timeliness of access to public healthcare services, family representatives and the person in charge confirmed their awareness of such issues and plan to address same.

The inspectors found that needs identified in the residents' healthcare assessments were generally cross-referenced in their personal planning arrangements and further addressed in residents' healthcare management plans. There was a suite of documentation introduced in 2017 for staff to record and measure the effectiveness of these plans for 2017. Some residents' personal planning arrangements were awaiting updating as they did not always show a close correlation between the findings of the healthcare assessment and the healthcare management plans developed. For example, for a resident diagnosed with hypothyroidism, a related healthcare management plan was not in place to complement the prescribed medicines. However, where this was identified during the inspection, it was resolved prior to the conclusion of the inspection. There were newly developed healthcare management plans developed for residents who

required support in their mental health. These plans were generally not signed or dated nor quality assured by the management team. The management team acknowledged the need for these plans to be signed off.

The review of the effectiveness of residents' healthcare plans was in its infancy due to the recently introduced personal planning arrangements. This meant that residents' healthcare goals were newly set and such progress notes regarding the achievement of goals in this area were not yet written.

The persons involved in the management of this centre informed the inspectors that on occasion, residents did not agree to have some clinical observations performed, for example, weight and blood pressure. There was not in all cases a risk assessment of this issue, although these were created prior to the conclusion of the inspection. The documentation did not explicitly state that medical practitioners were made aware of the refusal of the resident to engage in clinical observations.

The person in charge informed the inspectors that end-of-life care plans would be established, as per policy, when the need arose.

During the course of the inspection, inspectors reviewed one resident who had a choking episode in January 2017. Although the resident had been reviewed by a speech and language therapist (SLT) twice since this incident, it was noted on reviewing the resident's appointment list that the resident's last SLT review was in April 2017 with a note that the resident was to be reviewed again in three months. However, there was no record of any such review having taken place although inspectors were provided with evidence of an SLT referral that was made in the days before this inspection.

The needs of some of the residents were such that they required a high level of support from staff in their eating and drinking. Where required, each resident has their own individualised eating and drinking regime (as prescribed by a SLT). This information was displayed in each centre for all staff to see. During interviews, staff members could articulate the regimes of each resident. Some residents had plans issued to them by dietitians. These plans were also put into place by staff on a day-to-day basis.

At this centre, the main meal of the day was served at lunch-time and prepared by a service within the organisation. Staff prepared meals for the residents during the mornings, evenings and weekends and residents were also facilitated to visit restaurants and cafes in line with their peers. During interview, staff confirmed their awareness of the preferences of residents in this area.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Procedures were in place relating to medicines management to ensure that residents were adequately provided for in this area.

A sample of prescription and administration records were reviewed by inspectors. It was found that the required information such as the medicines' names, the medicines' dose and the residents' date of birth were contained in these records. Records indicated that medicines were administered at the time indicated in the prescription sheets and in the correct dose.

Secure facilities were in place for the storage of medication while fridges for storing medicines were also available in the designated centre. It was noted that records were kept which indicated that the temperature of such fridges were checked on a daily basis. Inspectors reviewed the storage facilities provided for medication and observed them to be neatly organised with no out-of-date medicines present.

Procedures were in place for the ordering of medicines; the records of monitoring and checks of stock levels were seen by inspectors. A separate space was provided for out of date or returned medicines and arrangements were in place for such medication to be collected as required.

Policies relating to medicines management were in place while audits in this area were also carried out. In the months before this inspection such audits were carried which covered areas of medicines management such as security, storage, stock and documentation. Any issues arising from these audits were followed up.

Judgment:

Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The centre had a statement of purpose that accurately described the service that was provided in the centre. It contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Adults and Children) with Disabilities) Regulations 2013.

Judgment:

Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

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

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

Findings:

There were systems in place for the governance and management of the centre. However, areas for improvement were identified in relation to the oversight by management of documentation, the follow up to audit findings and the findings of the annual review.

At the previous inspection, there had been a number of non compliances found in this area and an action plan response had been accepted by HIQA. At this inspection, these actions were seen to have been completed.

There was a clearly defined management structure in the centre. Care staff reported to the persons involved in the day-to-day management of the centre, who in turn, reported to the person in charge. The person in charge reported to the person representing the provider. Staff at all levels, including senior management and the person in charge were very familiar with the needs of the residents. The inspector observed a supportive working relationship between the person in charge and the staff team. The representatives of the resident confirmed to the inspector that they enjoyed good relations with the staff team, including management.

Although audits of various aspects of the running of the centre were performed, the follow-up actions to audit findings were not always clear. There was insufficient evidence to show the full oversight by the management team of records at the centre,

for example, healthcare assessments and plans did not always demonstrate clinical oversight.

The centre had undergone two six monthly unannounced inspections prior to this inspection and the inspector found that the person in charge was cognisant of the actions that had arose at those inspections and all actions identified had been closed off by her. The two six monthly inspections combined were slightly outside of the timeframes as set out by the regulations. However, the person representing the provider gave assurances to the inspectors that all six monthly inspections would be carried out going forward in the appropriate timelines, as set out by the Regulations.

There were systems in place for the annual review of the centre and the recent review contained a number of actions the person in charge was fully aware of and demonstrated actions to address the findings. The review included the viewpoint of family representatives. However, the annual review of the centre, performed shortly prior to this inspection failed to find that details of allegations made were not always reported to the designated officer.

The person in charge had a very good knowledge of the Regulations and knew the residents and staff team very well. She was a clinical nurse manager (CNM2) and had the relevant number of years of management experience. The person in charge was committed to her own personal development, as evidenced by her completion of training at post-graduate level and had commenced a module in healthcare management, in line with the Regulations. She was supernumerary on the roster and also involved in the day-to-day management of a second designated centre. The representatives of the residents knew her and confirmed that they spoke with her regularly.

The person in charge was supported by three persons involved in the day-to-day management of the centre, two of which the inspectors met with at this inspection. Both demonstrated a good knowledge of the Regulations, were aware of the responsibilities of their roles and were actively involved in the day-to-day management of the centre. Both knew the residents and their families very well.

Judgment:

Non Compliant - Moderate

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:

At the time of this inspection, inspectors were satisfied that there were appropriate levels of staff to meet the needs of residents. However, there was no system of formal supervision in place and some staff members were overdue refresher training.

Throughout the inspection positive interactions were observed between residents and staff members. Having observed practice and spoken with residents' relatives, management and staff members, inspectors were satisfied that there were appropriate numbers of staff to meet the needs of residents at the time of the inspection. Nursing care was also provided. However, there was an acknowledgement from the provider that staffing levels and the skill-mix would have to be closely monitored going forward to ensure they reflected the changing needs of residents, particularly in one unit of the centre.

Planned and actual rosters were maintained within the centre. A review of rosters indicated that staffing continuity was provided; this was confirmed by staff members and residents' relatives. Staff files were reviewed and all of the required documents were provided. Staff files were not reviewed during the course of this inspection.

Training records reviewed showed that all staff had received mandatory training. Staff members spoken with also indicated that they had received training and within relevant timeframes. However, records indicated that some staff were overdue refresher training in areas such as fire safety, manual, safeguarding, de-escalation and intervention. Inspectors were informed that staff members overdue refresher training were booked in to receive such training. It was also observed that there was a need for staff to be provided with training in mental health to reflect the needs of residents living in the centre.

Staff team meetings were taking place at quarterly intervals with a meeting schedule in place for 2017. A performance management system was operation in place. However, a process of formal supervision was not yet in place within the organisation. The need for a policy in this area had been identified in the provider's own annual review carried out in August 2017. Supervision had also been identified as an area for improvement at the previous inspection.

Inspectors were informed that there were no volunteers involved with the centre at the time of the inspection.

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:

This outcome was not inspected in full. Inspectors followed up on actions arising from the previous inspection.

It was noted on this inspection that an amended residents' guide had been put in place which contained all of the information required by the regulations. In addition, it was observed that a site-specific policy to guide and inform staff on the prevention of infection had been put in place while the health and safety statement had been reviewed.

As highlighted in the provider's own annual review, some aspects of recording required improvement, for example, a number of documents were not signed or dated (mental health plans). As highlighted under Outcome 7, the recording of fire drills to ensure that all key information including the time of day when such drills took place required improvement.

All Schedule 5 policies and procedures, as required by the Regulations, were in place, however, some were noted as to be outside of the three year timelines.

Indoor closed circuit television was used in two of the houses. This was described as necessary by staff for safety and behavioural support reasons. In one of the houses the CCTV was turned on and off at the discretion of staff. This was not in line with organisational policy which stated that CCTV when used was for 24 hours a day and seven days a week. The annual review of the centre recommended a local policy be created for the use of CCTV. The log records of use of CCTV were written in such a manner that the person in charge could not explain to the inspector the full usage.

All Schedule 5 policies and procedures, as required by the Regulations, were in place. However, some were noted as to be outside of the three year timelines.

The directory of residence had not, to date recorded the dates that a resident was not residing at the centre. This had also been found in the annual review of the centre. The person in charge confirmed to the inspector that since that finding was brought to her attention she had commenced the recording of same.

Judgment: Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Carol Maricle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003698
Date of Inspection:	13 & 14 September 2017
Date of response:	13 October 2017

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 05: Social Care Needs

Theme: Effective Services

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

There was insufficient evidence to demonstrate the effectiveness of the planning arrangements for each resident in the year prior to the inspection.

1. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan

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

reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

The Person In charge has put a system in place whereby all personal plans will be in line with current practice.

Proposed Timescale: 31/01/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

There was a malodour present in one of the rooms of an apartment. The hood of an oven required fixing. An internal refuse bin required replacement.

2. 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:

All repairs have been completed and bin has been replaced.

Proposed Timescale: 13/10/2017

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:

Some risks identified by inspectors relating to individual residents had not been risk assessed. The risk ratings applied to some residents' risk assessments relating required review to ensure that they accurately reflect the actual level of risk. Some risk assessments had not been reviewed in over 12 months

3. Action Required:

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

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

All risk assessments have been reviewed and rated appropriately

Proposed Timescale: 13/10/2017

Theme: Effective Services

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

Assurances were required regarding the fire safety arrangements in one unit of the centre.

4. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

A qualified competent person has been appointed to carry out assessment of area to ensure compliance with regulation.

Proposed Timescale: 30/11/2017

Theme: Effective Services

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

As on the previous inspection it was found that there were some gaps relating to weekly fire safety checks.

5. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

The persons participating in management have been assigned the responsibility for oversight of weekly fire safety checks .

Proposed Timescale: 13/10/2017

Theme: Effective Services

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

The information contained in two residents' PEPs did not reflect how these residents might react should an evacuation be necessary nor the assistance that was to be provided by staff. Some PEPs were not reviewed in over 12 months.

6. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

The two PEP'S have been reviewed to ensure all necessary information is included. PEP'S that were overdue review have now been reviewed .

Proposed Timescale: 13/10/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Not all of the restrictive practices used at the centre were applied in accordance with national policy.

7. Action Required:

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

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

All restrictive practices have been identified and reviewed .

Proposed Timescale: 13/10/2017

Theme: Safe Services

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

Some of the records pertaining to the use of restrictive practices did not set out how each use was only used following the exhaustion of all other methods.

8. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

All restrictive practices will clearly set out the measures that have been exhausted.

Proposed Timescale: 13/10/2017

Theme: Safe Services

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

There were allegations of abuse made that had not been processed in line with organisational policy.

9. 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:

Historic allegations of abuse are currently being screened with the assistance of the designated officer. A plan has been put in place where the designated officer will review any future allegations of abuse. Where an allegation has been made by a resident the person in Charge will respond immediately and the Provider Nominee informed.

Proposed Timescale: 13/10/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

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

The details of some restrictive practices had not all been submitted to HIQA on a quarterly basis.

10. Action Required:

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

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

All restrictive practices will be included in quarterly basis

Proposed Timescale: 31/10/2017

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:

Records did not explicitly state that medical practitioners were made aware of the refusal of the resident to engage in clinical observations.

11. Action Required:

Under Regulation 06 (2) (c) you are required to: Respect and document each resident's right to refuse treatment and bring the matter to the attention of the resident's medical practitioner.

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

Medical practitioner is aware of non compliance by resident to clinical observations and has signed personal plan where indicated.

Proposed Timescale: 13/10/2017

Theme: Health and Development

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

Where it was recommended that a review take place within a set time period, this was on one occasion, found to be outside of these timelines.

12. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

All referrals will be monitored by PIC to ensure timelines are met.

Proposed Timescale:

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:

Although audits of various aspects of the running of the centre were performed, the follow up action to findings was not always clear.

13. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

A process has been put in place to clearly set out actions from audits .

Proposed Timescale: 13/10/2017

Theme: Leadership, Governance and Management

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

The annual review of the centre carried out prior to this inspection failed to identify a number of allegations that had not been processed in line with organisational policy.

14. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure 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 accordance with standards.

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

The annual review will include any allegations of abuse.

Proposed Timescale: 13/10/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

Some staff were overdue refresher training in areas such as fire safety, manual, safeguarding, de-escalation and intervention. There was a need for staff to be provided with training in mental health to reflect the needs of residents living in the centre.

15. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

Training plan has been put in place . PIC is sourcing training in mental health for staff .

Proposed Timescale: 31/12/2017

Theme: Responsive Workforce

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

A formal system of supervision was not in place.

16. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

A policy on supervision is currently being developed by the Organisation.

Proposed Timescale: 30/11/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

All Schedule 5 policies and procedures, as required by the Regulations, were in place. However, some were noted as to be outside of the three year timelines.

Indoor closed circuit television (CCTV) was used in two of the houses. The use of same was not in line with the organisational policy.

17. Action Required:

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

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

All policies are currently being reviewed . CCTV usage is now in line with Organisational policy ,

Proposed Timescale: 30/11/2017

Theme: Use of Information

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

The directory of residence did not include the dates that residents had not resided at the centre in the 12 months prior to this inspection.

18. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

Any dates that residents do not reside in the centre ,both planned and unplanned are now recorded in the Directory of Residents .

Proposed Timescale: 13/10/2017

Theme: Use of Information

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

Log records of the use of CCTV were not clear.

19. Action Required:

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

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

Log records have been reviewed to ensure clarity .

Proposed Timescale: 13/10/2017

Theme: Use of Information

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

The recording of fire drills to ensure that all key information including the time of day when such drills took place required improvement.

20. Action Required:

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

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

Fire drill records now include time that drill takes place .

Proposed Timescale: 13/10/2017