

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by COPE Foundation
<b>Centre ID:</b>	OSV-0003306
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	COPE Foundation
<b>Provider Nominee:</b>	Colette Fitzgerald
<b>Lead inspector:</b>	Kieran Murphy
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	8
<b>Number of vacancies on the date of inspection:</b>	2

## 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:
04 December 2014 09:30	04 December 2014 18:00
05 December 2014 08:30	05 December 2014 15:30

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 04: Admissions and Contract for the Provision of Services
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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

The inspection was carried out in response to an application from the provider to register the centre which provided accommodation for 10 residents, all of whom required a high level of support.

As part of the inspection, the inspector met with the residents, relatives and staff members. A number of questionnaires, completed by relatives of residents, were received prior to and following the inspection. All responses reflected satisfaction with the care received with one specifically saying that "care in the centre is excellent". There was active community involvement with a recent project involving

the design, funding and building of a sensory garden for the residents which contained a waterfall, flower beds, a gazebo and numerous seating areas.

While there was a defined management structure this required review as both the person in charge and the provider nominee were actively managing a number of other centres across a broad geographical area. The inspector had reservations about these management arrangements across a number of centres as these arrangements could not ensure effective governance, operational management and administration of the designated centres concerned.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities. Improvement was particularly required in relation to the management of residents' finances. Other areas included:

- Privacy and dignity
- complaints
- fire precautions
- medication management
- statement of purpose
- residents' guide.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The process for managing residents' finances was not satisfactory. There was no designated committee at an executive level in the organisation with oversight of the management of resident finances. In addition there was no designated independent advocate to oversee the management of residents' finances. In relation to day to day expenses managed on behalf of residents two signatures by staff members were not in place for all credit and debit transactions. In relation to five residents the organisation was paying money belonging to the resident into a financial account which was not in the name of the resident to which the money belonged.

There were organisational standards and guidelines on the use clients' private property. These guidelines outlined that "central to the effective administration of clients private property was the need to clearly separate clients' funds from the Foundations funds." The financial affairs of four residents were being centrally managed by the organisation head office in accordance with these guidelines. This "Pocket Money Accounts system" was set up in 2005 and a recording system was set up to manage these accounts including individual ledger accounts.

There was evidence that residents were consulted about how the centre was planned and run. The inspector reviewed the minutes of the last two meetings of the residents' advocacy group. One resident specifically indicated a wish not to attend the advocacy meeting in November 2014. Picture communication cues were used at the meeting to get the views of residents regarding their preferences around issues including food, activities and the annual Christmas outing. There was evidence that the issues raised were all implemented following these meetings.

Closed circuit television (CCTV) was in use in all external areas including the main gates, all entrances/exits and gardens. There was signage advising that CCTV was in operation and there was a policy on the use of CCTV as part of the centre's overall policies procedures and guidelines.

There were six single bedrooms and two shared double rooms. While there were screens available in one of these double rooms to safeguard the privacy of residents who were sharing, screens were not available in the second bedroom. This issue of inadequate screening had been identified by the person in charge when completing the risk register with plans to be put in place to budget for permanent screens to be erected in both double rooms.

The inspector saw personalised living arrangements in residents' rooms with photographs, personal effects and furniture. There was adequate space for clothes and personal possessions in all bedrooms with adequate wardrobes and lockers. There was an up to date property list in each resident's personal outcomes folder.

There was a complaints policy which was also available in an easy to read format. However, the policy did not identify a nominated person with oversight of the complaints process to ensure that all complaints were appropriately responded to as required by regulation 34. While the complaints log was being updated, the majority of complaints recorded were actually maintenance issues. There was one complaint relating to clothes going missing. It was recorded that a meeting was held with the resident and their family and it is recorded that the complainant was satisfied with the outcome.

**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):**

This was the centre's first inspection by the Authority.

### **Findings:**

There was a policy on communication dated March 2014. In the sample of healthcare files seen by the inspector each resident had a communication "passport", developed in conjunction with the speech and language therapy department in an easy to read format. The passport identified issues including:

- How the resident communicated
- how people could help the resident to communicate

- things the resident liked to communicate about
- listening/sight requirements e.g. if they used a hearing aid or glasses.

There was also a communication of need review concentrating on issues for the resident in terms of "I want" and "I need". This review used pictures to guide the resident to identify their "wants" and "needs".

Communication folders were available in one of the living rooms which outlined in picture format important things in the resident's life including family, friends, things they enjoyed doing and holidays. There was an activities board in the dining room which had pictures of what activities the residents were doing each day of the week. There was also communication board in the dining room outlining recommendations by the speech and language therapist in relation to how food was to be prepared and presented for each resident.

Television was provided in the main living rooms and a number of residents had televisions in their own room.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The centre recently opened a sensory garden which included footpaths, flower beds, a water feature and a seating area set amongst large mature trees. This was a community initiative led by the Lions Club and the local family committee of the organisation. Funds were raised from local businesses, schools and interested people in the community. The garden was designed by a local landscape gardener. One family member specifically commented on how great it was to see the residents enjoying the sensory garden.

The chief executive officer had recently written to each resident and their families inviting them to attend a family forum with the aim of improving communication between the organisation, the families and the residents.

There was an open visiting policy and families with whom inspectors spoke confirmed that there were no restrictions on visits. There were a number of areas throughout the centre where each resident could receive visitors in private. The inspector received a

number of completed relative questionnaires from family members which were highly complimentary of the service.

**Judgment:**  
Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**  
Effective Services

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

This was the centre's first inspection by the Authority.

**Findings:**

There was a policy on contracts of care. The inspector reviewed a sample of contracts of care and each had been agreed and signed by the resident and/or their families.

The contract outlined the arrangements for:

- Services and supports
- food/nutrition
- clothing
- personal property
- visits
- temporary absence
- discharge
- care planning
- healthcare
- finances
- rights/responsibilities
- fees and charges.

There was a separate admission/transition and discharge policy which specifically outlined that the organisation took account of the need to protect residents from abuse by their peers.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

There was a named key worker with responsibility to ensure each resident had a personalised care plan. The person centred plans had evidence of family input. The person in charge had written to each resident's family inviting them to a meeting to plan the resident's goals for the year. There were agreed time-frames in relation to achieving identified objectives with named staff members responsible for pursuing objectives with residents. In the sample annual plans reviewed by the inspector issues discussed included the resident's health needs, what activities they liked doing and the purchasing of personal items like clothes. The person-centred planning folder also contained a picture of the resident, personal details and family contacts. There was also relevant information relating to medical history and important things to know about the resident like allergies to medication.

In the sample records seen by the inspector particular attention was given to risk assessment in relation to issues like oral hygiene, bone health assessment, resident handling, mobility and maintaining a safe environment. There was evidence that, as required, care was planned also for pressure ulcer development.

One family member outlined that when a resident had been admitted recently to an acute general hospital a plan of support was put in place, which included staff staying with the resident at night for the length of hospitalisation. Medical and nursing discharge information in relation to hospital admissions was available in the healthcare file. In each person-centred planning folder there was a form, "relevant information to accompany clients being admitted to acute care", available which was also given to the receiving hospital. The person in charge outlined that if a resident had to attend an out-patient appointment a staff member would accompany the resident.

**Judgment:**  
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):**

This was the centre's first inspection by the Authority.

**Findings:**

The centre provided accommodation for ten residents in a large house set on approximately an acre of ground. There was a newly created sensory garden which is discussed in more detail in Outcome 3. Access was via secure gates with closed circuit television cameras in situ.

The entrance of the house contained a large hallway which led to a living room with couches and a television. Opposite the living room was a dining room and a kitchen. The kitchen had an adjacent pantry area which contained a locked medication fridge. There was a boiler house outside. On the first day of inspection the boiler house contained some potentially flammable waste material on the ground but this was removed immediately by the person in charge. There was a second living room which also contained a number of couches and a television. There was access to an enclosed patio area from this room. The staff office was accessed via a locked door in this living room.

There were six single bedrooms on the ground floor each with a wash hand basin. There were two double bedrooms. All bedrooms were decorated according to resident's personal choice. The ground floor also contained a laundry room. There were two bathrooms each with a shower, toilet and wash hand basin. A third bathroom had a toilet and wash-hand basin.

The first floor was used by staff and contained a meeting room, a store room, three bathrooms and three further spare rooms.

The inspector viewed the maintenance log and saw that all requests for maintenance were carried out as quickly as possible. Contracts were in place to manage issues including security of the premises, waste management, gas and fire extinguishers. There were handrails available throughout the premises to assist any resident with visual impairment to move unaided.

**Judgment:**

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):**

This was the centre's first inspection by the Authority.

**Findings:**

The risk management policy included, in an appendix to the policy, the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. There was a centre specific risk register which identified hazards and controls in place for issues including: fire, use of the stair gate from the ground floor to first floor, security of the premises, laundry, storage of the oxygen cylinder and medication management.

There were two separate methods for recording adverse events namely accident reporting and incident reporting. The accident log had seven recorded falls since January 2014. There was evidence that all accidents were followed up appropriately and two were the subject of an accident report review which was utilised for more serious accidents and included actions to prevent the accident happening again. The incident report log contained four incidents, two relating to medication management, one relating to damage to a vehicle and the fourth where a resident's leg was caught in a shower chair.

There was a fire evacuation plan which identified the arrangements in place to respond to emergencies like fire, loss of power, loss of heating and loss of water supply. There was a letter on file from a hotel in the town confirming that in the event of an emergency the residents would be accommodated in the hotel. In the sample healthcare files seen by the inspector each resident had a personal emergency evacuation plan.

There was a policy in relation to control and prevention of infection and the centre was visibly clean. There were cleaning schedules in place and staff spoken with were aware of infection control principles. In relation to laundry residents placed clothes for washing in baskets in the bathrooms and these were washed at night. Water soluble bags were available for any items that were soiled and required separate washing.

There was confirmation, dated January 2014, from a properly and suitably qualified person that all statutory requirements relating to fire safety and building control had been complied with. However, fire doors were being kept open with wedges. The person in charge outlined that this was to assist people with vision impairment to walk around the house unimpeded.

The inspector saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained with a certificate of testing and servicing of fire alarm system December 2014. There was also documentation confirming that the fire extinguishers had been inspected and serviced. At the fire panel there was a fire bag which contained the resident personal emergency evacuation plans, a torch and a high visibility vest. There was daily checking of the means of escape route and a fire drill was undertaken at least every two weeks.

Not all staff had been trained in fire safety within the last year with one staff due to receive training in January 2015.

**Judgment:**  
Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**  
Safe Services

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

This was the centre's first inspection by the Authority.

**Findings:**

A specific incident relating to adult protection had been notified to the Authority and was outlined in more detail during the inspection. Documentation reviewed by the inspector demonstrated that the incident had been followed up in accordance with the centre policy by the person in charge. There was a policy on protection of vulnerable adults and all staff had received training on the prevention of abuse. There was a separate policy on intimate care and the sample healthcare files contained intimate care plans.

There was a policy on the provision of behavioural support and a separate policy for the prevention of and use of restrictive intervention. Any resident who required the use of restraint, for example a bed rail, had a risk assessment undertaken and an agreement was in place with the resident and family on the use of the bed rail.

A behavioural therapist was available and inspector saw evidence that residents had received support from the therapist. From a selection of behaviour management plans viewed by the inspector, behavioural intervention records gave clear directions to staff on how best to prevent or appropriately respond to behaviour that challenges. The behaviour assessment reports included an analysis and observation of the behaviour being assessed, the results of the observations and strategies to be put in place to reduce the behaviour. There was accurate recording by staff of the behaviour when it occurred.

One resident was using a tilt-in-space chair which provided support for postural management. An occupational therapist had undertaken an assessment with the resident and recommendations were available on the ways to promote the best use of this chair while sitting, transferring, using the shower and how to relieve pressure on the

resident's joints.
<b>Judgment:</b> Compliant

<b>Outcome 09: Notification of Incidents</b> <i>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</i>
<b>Theme:</b> Safe Services
<b>Outstanding requirement(s) from previous inspection(s):</b> This was the centre's first inspection by the Authority.
<b>Findings:</b> Practice in relation to notifications of incidents was satisfactory. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents have been notified to the Chief Inspector.
<b>Judgment:</b> Compliant

<b>Outcome 10. General Welfare and Development</b> <i>Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.</i>
<b>Theme:</b> Health and Development
<b>Outstanding requirement(s) from previous inspection(s):</b> This was the centre's first inspection by the Authority.
<b>Findings:</b> The person in charge outlined that close links were maintained between the organisation and the local secondary schools. Some transition year students had undertaken fundraising for the sensory garden and pupils and teachers had attended the official opening of the garden. A number of residents had attended the schools and participated in arts and crafts classes. Residents had also been invited to attend the Christmas show in one school.  One resident accessed a day activation centre managed by the organisation and the

provider outlined that this service provided supports and training in issues like computer skills, baking and art. The person in charge outlined that a number of residents attended the Ozanam resource centre on a regular basis to undertake activities like baking. A number of residents had certificates of participation on display in their bedrooms for example participating in an integrated community sports event in October 2014.

There was an activities coordinator five days per week. Each resident had an individualised activities folder which outlined things they liked to do including swimming, baking and accessing local restaurants. During the inspection there was a schedule of activities including swimming in the local leisure centre, painting and a disco/music evening coordinated by one resident's brother. The staffing levels had been increased recently to three staff on the weekends also to facilitate residents to participate in activities in the community.

**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):**

This was the centre's first inspection by the Authority.

#### **Findings:**

The inspector reviewed a sample of resident healthcare files. Each resident had an up to date annual medical report completed by their general practitioner (GP). Nursing staff also undertook an annual OK health check which was a global health assessment. These reports were used as a method of reviewing care for the resident for the previous 12 months and also to plan future care. For example following these reviews one resident was referred for a follow up scan in an acute general hospital; another resident was referred to a consultant specialist for a review appointment.

There was evidence in the healthcare records that the GPs were reviewing residents' health needs as required also. There was regular blood testing for residents on particular medications to ensure that the levels were within recommended ranges.

A record was maintained of all referrals to and treatment by allied health professionals. This included dentist, optician and chiropodist. Following an optician appointment one resident had been referred for surgery to correct a vision impairment. In this instance a copy of the discharge summary from the ophthalmic surgeon was available in the healthcare record. One resident had a specific positioning programme recommended following a physiotherapy assessment. There was evidence that residents' emotional

needs were also being met with a number of residents being referred for counselling following a bereavement.

There was a policy and guidelines on nutrition and hydration. Each resident's personal care planning folder contained recorded discussions with residents on their particular food likes and dislikes. There was an eating and drinking audit undertaken also to highlight residents' preferences at mealtimes. A number of residents had swallow care plans recommended by speech and language therapists which guided how meals were to be prepared for each resident. There was a three week menu and a copy of the menu was available on the notice board. Staff prepared all meals with a copy of the swallow care plans available in the kitchen.

At meal times the dining room tables were set in an attractive manner. The inspector noted that lunch, in sufficient portions, was plated and presented in an appetising manner. For residents requiring food in a modified format this was served in an appealing manner also. Assistive cutlery and crockery required for residents with reduced dexterity was provided. Staff were observed assisting residents in a sensitive manner and used the mealtimes as an opportunity to communicate and interact with residents.

**Judgment:**

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):**

This was the centre's first inspection by the Authority.

**Findings:**

There was a policy on medication management which outlined that that "medication can be administered by delegated staff who have undertaken responsible and safe medication management". However, some non-nursing staff who had not completed this training were administering medication from time to time. The inspector found that this lack of training increased the possibility of error.

Medication was dispensed from the pharmacy in a monitored dosage system. The medication was checked by nursing staff on delivery from the pharmacist. It was kept securely in a locked cabinet in a locked office.

Based on the sample of prescription sheets reviewed a record of each drug and medication was signed and dated by a medical practitioner.

Photographic identification was available for each resident on the medication administration record to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. Nursing staff outlined that three residents required medication to be administered in a modified form to that prescribed (i.e. crushing an oral medication that was in tablet form) and therefore the medicinal products were being used outside the licensed conditions. In one resident's prescription sheet not all medications were indicated as needing to be crushed even though nursing staff were administering the medication in a crushed format.

In the sample of prescription sheets reviewed each resident's medication was reviewed at least six monthly by the GP, with any changes documented also in the healthcare file. The pharmacist had undertaken two audits, one in August 2014 and the other in November 2014. The audits reviewed issues including:

- Medicine supply
- medicine storage
- medicine ordering
- disposal of medications.

Any issues identified in these audits were acted upon by the person in charge.

**Judgment:**

Non Compliant - Moderate

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The statement of purpose did not identify all the bedrooms available to accommodate ten residents. The statement of purpose also didn't confirm whether there were any separate facilities for day care.

**Judgment:**

Non Compliant - Minor

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The statement of purpose defined the management structure and identified the lines of authority and accountability from the person in charge to the provider nominee. The person in charge was employed full time and was found to have the qualifications, skills and experience necessary to manage the centre. She was also appointed as person in charge for four other centres across a broad geographical area. The provider nominee outlined that she too had responsibility for a number of other centres across a wide area. The inspector outlined his concern that these management arrangements across a number of centres could not ensure effective governance, operational management and administration of the designated centres concerned.

There was evidence of audits of care including:

- Intimate care. This audit, undertaken in September 2014, had identified that screening needed to be ordered for both double bedrooms. However, this had only been completed for one room.
- mattress audit
- hand hygiene
- privacy and dignity
- protected mealtime.

The provider had arranged for a number visits to the centre in the last six months to assess quality and safety. However, there wasn't an annual review of the quality and safety of care and support as required by the regulations.

**Judgment:**

Non Compliant - Major

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management
<p><b>Outstanding requirement(s) from previous inspection(s):</b> This was the centre's first inspection by the Authority.</p> <p><b>Findings:</b> The person in charge had not been absent for a prolonged period. However on a day to day basis the senior nurse on duty had responsibility for the centre.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 16: Use of Resources</b> <i>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</i></p>
<p><b>Theme:</b> Use of Resources</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> This was the centre's first inspection by the Authority.</p> <p><b>Findings:</b> The inspector formed the opinion that the centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. The centre was maintained to a good standard inside and out and had a fully equipped kitchen and laundry. Equipment and furniture was provided in accordance with residents' wishes. Maintenance requests were dealt with promptly.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 17: Workforce</b> <i>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.</i></p>
<p><b>Theme:</b> Responsive Workforce</p>

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

This was the centre's first inspection by the Authority.

**Findings:**

The inspector found that, based on the assessed needs of residents, there were sufficient staff with the right skills, qualifications and experience to meet those needs. Staffing levels reflected the statement of purpose and size and layout of the houses. As discussed earlier in Outcome 10 additional staff had been employed at the weekend to ensure residents could participate in activities based in the community. An actual and planned staff rota was maintained. A copy of this rota was available in a picture format in all of the houses so that residents were aware of which staff were on duty.

The inspector reviewed a sample of staff files and found that all of the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities were available.

There was a staff training and development policy and all staff had received the required training except for fire training which is discussed in Outcome 7.

There were a number of volunteers and the inspector saw that there was a written agreement in place.

**Judgment:**

Compliant

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

While there was a records management policy in place, the management of healthcare records required improvement. In some healthcare files seen by the inspector reviews

by consultant specialists were filed in plastic pockets at the back of the healthcare record. This system did not adequately ensure that relevant healthcare information was available to plan care for residents.

A directory of residents was maintained in the centre and was made available to the inspector.

The residents' guide, did not include the following items which are specified in the regulations:

- Accurate summary of the facilities
- staffing levels
- arrangements for resident involvement in the running of the centre
- how to access previous inspection reports.

The inspector was provided with a copy of an insurance certificate which confirmed that there was up to date insurance cover.

All of the policies and procedures as required by Schedule 5 of the Regulations were available.

**Judgment:**  
Non Compliant - Minor

## 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:***

Kieran Murphy  
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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by COPE Foundation
<b>Centre ID:</b>	OSV-0003306
<b>Date of Inspection:</b>	04 December 2014
<b>Date of response:</b>	30 April 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:**

Screening arrangements were not in place to safeguard the privacy of residents who were sharing one double bedroom.

**Action Required:**

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

A moveable screen has been ordered and we are awaiting delivery of same (before 15/05/2015). On delivery these will be available to be utilised in both of the double bedrooms as required.

**Proposed Timescale:** 15/05/2015

**Theme:** Individualised Supports and Care

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

Two signatures were not in place for all credit and debit transactions.

**Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

The person in charge met with all staff to ensure that there are 2 signatures in place for all debit and credit transactions. There is now a laminated sign on the press where all of the financial records are kept. The importance of double signatures on all financial transactions will be discussed at each staff meeting.

**Proposed Timescale:** 30/04/2015

**Theme:** Individualised Supports and Care

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

In relation to six residents the organisation was paying money belonging to the resident into a financial account which was not in the name of the resident to which the money belonged.

**Action Required:**

Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

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

Currently there is not a designated advocate to oversee the management of residents finances, however the person in charge ensures that support is provided to manage all

residents financial affairs and has arranged for the team leader to oversee the management of these residents finances. The person in charge met with all staff to ensure that two signatures are in place for all debit and credit transactions.

In relation to the finances of five residents, follow up contact has been made with their families. We can confirm that for one resident, the resident is named on the account. In relation to a second resident, Cope Foundation is not the receiving agent for the disability allowance, and the financial affairs are managed by the family. In relation to the three other residents who do not have the capacity to consent, Cope Foundation has communicated with these families and discussions are on going to arrange that these residents are named on the accounts.

**Proposed Timescale:** 30/06/2015

**Theme:** Individualised Supports and Care

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

Complaints log was not being updated appropriately.

**Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

Person in Charge met with all staff and reiterated the importance of logging all complaints in the complaints log especially those pertinent to the residents. This will be discussed at all staff meetings in 2015.

PIC will oversee the complaints log and ensure actions and outcomes are addressed for the complaint in as far as practicable.

**Proposed Timescale:** 30/04/2015

**Theme:** Individualised Supports and Care

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

Complaints policy did not identify a nominated person with oversight of the complaints process to ensure that all complaints were appropriately responded to.

**Action Required:**

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are

maintained.

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

The person in charge of each area deals locally with complaints in the first instance; the provider nominee Colette Fitzgerald has oversight of the complaints process to ensure that all complaints were appropriately responded to at a monthly meeting between PIC and provider nominee.

Currently the Cope Foundation policy does not identify specific Provider Nominees, as this is a generic policy.

The nominated person with oversight of the complaints process to ensure that all complaints were responded to as required as per regulation 34.

The policy will be updated to identify this person and you will be forwarded this change in policy by 31-5-2015.

**Proposed Timescale:** 31/05/2015

**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:**

Fire doors throughout the ground floor were being wedged open.

**Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

A requisition has been sent to maintenance for magnetic automatic door releases to be put on all of the fire doors that are currently being held open by wedges.

All wedges have been removed and the magnetic door releases are currently being installed.

**Proposed Timescale:** 08/05/2015

**Theme:** Effective Services

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

Not all staff had been trained in fire safety.

**Action Required:**



Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

The staff member in question has had her fire training completed 06-01-2015

**Proposed Timescale:** 06/01/2015

**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:**

Non-nursing staff who had not completed medication administration training were administering medication from time to time.

**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:**

An in-house medication management training course will be arranged for all care staff. Medication management training will be completed for remaining staff on 28/05/2015

**Proposed Timescale:** 28/05/2015

**Theme:** Health and Development

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

Not all medications were indicated as needing to be crushed even though nursing staff were administering the medication in a crushed format.

**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:**

All medications that require crushing are now signed and dated by the GP.

**Proposed Timescale:** 30/04/2015

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not identify all the bedrooms available to accommodate ten residents.

**Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The statement of purpose has been amended to reflect the number of bedrooms available to accommodate residents.

Amendments will be implemented in the Statement of Purpose to reflect the change in organisational and managerial structure in line with Regulation 23(1) (c)

**Proposed Timescale:** 31/05/2015

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not confirm if there were any separate facilities for day care.

**Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The statement of purpose will be amended to clarify the facilities available for day care.

**Proposed Timescale:** 30/04/2015

**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:**

While there was a defined management structure this required review as both the person in charge and the provider nominee were actively managing a number of other centres across a broad geographical area.

**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:**

In January 2015 a new Head of Homes & Community was appointed with responsibility for centres providing services to people with challenging behaviour in Cork City. The result of this appointment is that Colette Fitzgerald; Provider Nominee for Dun Aoibhinn, Fermoy, Bracken Respite, Fermoy and The Lodge, Mitchelstown, has had a reduction in the number of PIC's reporting directly to her from 7 to 5.

Team leaders have recently been appointed to support the current Person in Charge responsible for the above listed designated centres. The team leaders are currently being processed as PPIM's and the documentation is being completed. These team leaders will have 6 hours of protected time each week to support the Person In Charge.

The Team Leaders will attend a one day training course in relation to clarification of their roles and responsibilities.

Cope Foundation will advertise internally and externally for an additional CNM1 to take on the role of a Person in Charge. This person in charge will have responsibility for the following areas:

Dun Aoibhinn, Fermoy, Bracken Respite, Fermoy and The Lodge, Mitchelstown.

The newly appointed PIC will then be able to have a presence in each centre 2 to 3 days per week

The current Person in Charge will remain within Dun Aoibhinn, Fermoy, Bracken Respite, Fermoy and The Lodge, Mitchelstown until the post is advertised and allocated for the designated centres.

The Provider Nominee for North Cork, will continue to provide on-going support and guidance to the current Person in Charge, and will support the additional PIC once recruited.

The appointment of two PIC's in North Cork together with the support of a PPIM structure will aid Cope Foundation to ensure that services provided are safe, consistent and appropriate to residents' needs.

As part of the Management and Control of Operations in North Cork this new structure will assist an effective management system. The Provider nominee has recently

completed an unannounced visit to the areas in North Cork and will continue to be a presence on site to support the Persons in Charge in the future.

**Proposed Timescale:** 31/05/2015

**Theme:** Leadership, Governance and Management

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

There wasn't an annual review of the quality and safety of care and support.

**Action Required:**

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

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

Cope Foundation commissioned an external review of quality and safety in all Designated Centres. This review has commenced in a centre in Cork City already registered by HIQA. It is expected that the annual review of services in Mitchelstown will commence in 8 months.

**Proposed Timescale:** 30/11/2015

## **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

The residents' guide did not include the following items which are specified in the regulations:

- The terms and conditions relating to residency
- arrangements for resident involvement in the running of the centre
- how to access previous inspection reports.

**Action Required:**

Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

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

The residents guide will be updated to include

- The terms and conditions relating to residency
- arrangements for resident involvement in the running of the centre
- how to access previous inspection reports.

**Proposed Timescale: 30/04/2015**

**Theme: Use of Information**

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

Relevant healthcare records were not easily accessible.

**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:**

A request has been made to the GP services to forward on all relevant health care records from GP visits to consultant appointments.

**Proposed Timescale: 31/05/2015**