

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003695
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Bernadette O'Sullivan
Lead inspector:	Julie Hennessy
Support inspector(s):	Kieran Murphy;Noelle Neville
Type of inspection	Announced
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
26 January 2016 09:00	26 January 2016 18:30
27 January 2016 08:30	27 January 2016 16:30

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 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the first inspection of this centre following an application by the provider to register the centre.

The centre consisted of four houses, three of which were in the suburbs of Cork city with the fourth house approximately six miles away in a satellite town. The centre provided both full-time residential care and respite care for shorter periods of time. The person in charge maintained a record of all residents who accessed the service on a respite basis.

Three residential houses in this centre were on a complex by themselves and met the definition of a congregated setting. Each of the three residential houses could accommodate between eight and ten residents. The fourth house was a community house that provided both residential and respite services and could accommodate six residents. Four bedrooms in the centre were shared bedrooms. Overall the centre was warm, clean, well maintained and well presented.

Inspectors reviewed and discussed the organisation of the designated centre and the

arrangements in place for the person in charge of the centre. Inspectors found that the person in charge was responsible for this centre and three other designated centres. Having discussed the arrangements in detail, it could not be demonstrated that this arrangement could ensure the effective governance, operational management and administration of the designated centres concerned.

As a result, inspectors did not proceed with the planned 18-outcome inspection that was originally scheduled to inform the registration of this centre. The provider was requested to submit a proposal to HIQA within 10 working days with respect to ensuring the effective governance and management of the centre both with respect to reviewing the remit of the person in charge and reducing the size of the designated centre itself. A monitoring inspection was completed instead.

A number of good practices were identified over the course of the inspection. Residents told inspectors that they felt happy and safe in the centre. Staff were observed to interact with residents in a supportive and appropriate manner. Residents' healthcare needs were met through timely access to medical, nursing and allied health professionals. Residents however identified that they did not get to go out as much as they would like and individual residents said that they would like to live with different people or in a smaller group.

A number of relatives visited the centre over the course of the inspection. Overall, the feedback from relatives was very positive with respect to the care and service that their loved one received in the centre. Relatives said that staff were approachable, that they were always welcome to visit and that they were kept informed of any changes that arose. Individual relatives did identify some key areas for improvement, for example, how they might appeal the outcome of a complaint, shared bedrooms and relatives said that they would welcome being invited to attend a formal annual review of their loved ones' personal plan.

However, inspectors found a significant number of non-compliances against the Regulations. Of the ten outcomes inspected, two were at the level of major non-compliance, six at the level of moderate non-compliance, one was substantially compliant and one outcome was fully compliant.

The two outcomes at the level of major non-compliance related to outcomes 5 and 14:

Under Outcome 5: Social Care Needs, significant failings were identified with respect to the individualized assessment and personal planning process. Residents' personal plans were not based on an assessment of their needs, abilities and wishes. There was no formal process in place to review the personal plan annually or more frequently if there is a change in needs or circumstances or to ensure that such a review was multidisciplinary, as required by the regulations. Where the centre did not meet residents' needs, abilities or wishes, alternatives and options were not being planned or discussed. Where residents' needs increased, there was no evidence of planning to meet their changing needs. Also, it was not demonstrated that discharges from the centre took place in a planned manner.

Key failings under Outcome 14: Governance and Management of the centre are discussed above and relate to the arrangements concerning the person in charge of the centre.

Findings are detailed in the body of the report and should be read in conjunction with the actions outlined in the action plan at the end of the report.

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 organisation had a complaints policy and easy-to-read versions were visibly displayed throughout the centre. It was demonstrated that it had been discussed with residents how to make a complaint. The complaints policy identified a nominated person to manage complaints in the organisation. However, it did not identify a second person to oversee how complaints were managed, as required by the Regulations and as a result, the appeals process was not clear. Inspectors spoke with relatives who said that they would have no difficulty with raising a complaint, should they wish to do so. However, relatives were not clear how to appeal the outcome of a complaint if they were not satisfied with that outcome. This finding reflected the absence of an appeals process in line with the requirements of the Regulations in the organisation's complaints policy.

Inspectors reviewed complaints logs maintained in each unit within the centre. While some complaints were completed in accordance with the Regulations, others were not. For example, one entry did not detail whether complainants were satisfied with the outcome of the complaint, another entry was unsigned and undated and one log was incomplete due to transfer of information from 2015 to 2016. The outcome was unclear with respect to two other complaints; in one complaint it was only recorded that the clinical nurse manager (CNM) was informed and for another complaint relating to a resident not being happy that another resident was hitting him the response was unclear. Five complaints related to staffing where residents had complained that they could not go out or participate in social outings due to no staff being available to facilitate same.

Staff practices were observed to be respectful of residents' privacy and dignity. Bathroom and bedroom doors were kept closed. Residents' personal possessions were respected. Sleeping accommodation in the centre comprised either single or twin bedrooms. Where residents shared a bedroom either in a respite or residential setting, inspectors asked a number of residents whether they were happy with this arrangement. While all residents with whom inspectors spoke said that they were happy with this arrangement, individual residents said that it depended on who they shared with. There was one entry in the complaints log from a resident who didn't sleep well because of the person sharing her room. Inspectors observed that there was no privacy screening available in shared bedrooms. The person in charge said that a funding application for fixed privacy screening had been made three years in a row but had not yet been approved. The person in charge explained that mobile screening would not be suitable for residents in this centre.

However, questionnaires that had been completed by residents or with residents indicated that (in two houses) residents expressed that they were not always happy with who they lived. For example, one resident did not like arguments between other residents in the house and another resident said that they "would not feel safe" when another resident would "kick off". In addition, one resident said that they would like to go out more in the evenings and another resident would like to live with a smaller group of residents. This will be further discussed under Outcome 5.

Inspectors found that residents were not consistently afforded the opportunity or assistance when providing consent and making decisions about their care and support. In some circumstances, parents provided consent for residents in relation to the provision of intimate care and administration of medicines. The provider nominee was aware of the recently introduced 'Assisted Decision-Making (Capacity) Act (2015)' and inspectors highlighted the requirement for the organisation to review their procedures in line with this Act.

Residents' personal plans outlined individual resident's likes and dislikes, activities and interests. Inspectors reviewed minutes of residents' meetings. Topics discussed included how to advocate for oneself, what people like to do in the evenings and how to make choices and be involved in decisions. However, these meetings were a very recent introduction with only one meeting per house having been held to date since commencement of the Regulations.

Residents told inspectors that they enjoyed a range of activities and interests. These included participating in the Special Olympics in soccer or gymnastics, going to the cinema, going for drives or walks, dancing, knitting, attending matches, meeting their friends and going for coffee, tea or dinner. Residents also said that they went on holiday with their families or home for the weekend or holiday periods. However and as mentioned above, staffing arrangements at times limited residents' choice and options. For example, in one house, there was one staff member on the roster with up to six residents. As a result, decisions had to be made collectively as a group as to where to go or what to do. Staff did however endeavour to facilitate individual variation where possible, such as making transport arrangements with other houses to allow an individual join a group activity at a later time. Also, for pre-planned activities or events, additional staffing was made available. The action relating to staffing can be found

under Outcome 17, Workforce.

In addition, not all practices facilitated independence or choice. Some plans and programmes that were required were not in place to support individual residents to make healthy choices, form and maintain healthy personal relationships or manage personal finances, in accordance with their abilities and wishes. For example, where a risk assessment said that a resident could not walk to the day service unsupervised, this was contradicted by other information that assessed the resident as being safe crossing the road. It was not demonstrated that risk control measures were proportionate or that the impact on the resident's quality of life had been considered.

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:

Findings in relation to how residents' communication needs were inconsistent.

All residents had a communication profile in their personal files. Some residents with communication needs were supported to communicate and express choice, for example, through sign language and pictures. Where residents had a hearing impairment, there was evidence of regular review by audiology and the provision and maintenance of aids and appliances.

However, this was not a consistent finding. It was not demonstrated that options available to support all residents to communicate had been adequately explored. For example, not all residents had a 'communication passport' that passed on key information about how an individual communicates and understands. The person in charge explained that this area was currently being developed. Some residents with communication needs did not have a communication passport and inspectors found that information contained in their communication profiles in relation to how staff should communicate with residents was broad in nature and where a resident used an iPad and a communication app this was not included in their profile. For those same residents, there were no communication care plans and no evidence of specialist input with respect to consideration of the use of assistive technologies or devices.

Judgment:

Non Compliant - Moderate

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:

Each resident had a personal plan. Personal plans contained a personal profile, pictures of residents' family and friends, personal goals, individual likes and dislikes, weekday activity schedule, health assessments and checks, a self-assessment questionnaire, a support plan for intimate care, activities and outings, risk assessments and behaviour support plans (if required) and a record of visits and contacts with family and friends. Residents knew their plans and some residents were happy to show and explain their plans to inspectors. However, it was not demonstrated that families were invited to participate in the development of personal plans with residents, where appropriate and in accordance with residents' wishes, age and the nature of his or her disability.

A comprehensive assessment was in place with respect to residents' healthcare needs. However, a comprehensive assessment was not in place with respect to residents' social, employment, training and personal development needs, as required by the Regulations.

As a result, inspectors found that residents' goals were not based on a comprehensive assessment of resident's needs, abilities and wishes. For example, long-term goals, such as where a resident may wish to live in the future and with whom, or educational and training goals were not included in the personal plan. As a result, it could not be demonstrated how residents' wishes were being considered and examples have been given in Outcome 1 of residents who wished to live with other people or in a smaller group. Also, the supports required to ensure residents achieve their goals were not specified, in terms of staff, transport, facilities or other necessary supports. In addition, inspectors found a number of failings with respect to personal planning and review of residents' personal plans.

Significant failings were identified with respect to the review of the personal plan. There was no formal process in place to review the personal plan annually or more frequently if there is a change in needs or circumstances or to ensure that such a review was multidisciplinary, as required by the Regulations. As a result, families did not have the opportunity to attend an annual review. When asked, a number of relatives told

inspectors that they would welcome such an opportunity.

The impact of failings regarding the multidisciplinary review of the personal plan was evident in a number of ways. Where the centre did not meet residents' needs or abilities, alternatives and options were not being planned or discussed. The person in charge identified a number of residents who could be more suited to living either more independently or alternatively, in an environment with increased supports. As a result, the suitability of the centre to meet the needs or abilities of residents' was not being assessed, reviewed and alternatives pursued in a planned way with the multi-disciplinary team. For example, for a resident who currently presents with increasing healthcare needs, there was no plan in place to meet their changing needs and circumstances.

Also, it was not demonstrated that discharges from the centre took place in a planned manner. Inspectors reviewed the file of a resident who had transferred from this centre to another centre in response to increasing healthcare needs. There was no evidence of planning with respect to this move or any evidence of such a move being considered by the multi-disciplinary team. The person in charge told inspectors that she had met with the resident and their family with respect to the move.

Inspectors found that the failings relating to the review of the personal plan and planning for discharges from the centre was a major deviation from the Regulations with the potential for major impact on the outcome of care or the quality of the service being provided and as such, was at the level of major non-compliance.

Judgment:
Non Compliant - Major

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:

There was a risk management policy that included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self-harm. All of these issues were also identified as hazards and had been separately assessed and risk-rated.

Inspectors reviewed the incident reports and saw records for 43 incidents, 84% of which had occurred in one house. The total incidents included nine resident falls and ten incidents of residents assaulting other residents or staff. There was evidence that incidents were being followed up appropriately. In addition, the person in charge

outlined that incidents were reviewed by the service's quality and safety steering committee. Inspectors reviewed minutes of the most recent quality meeting from January 2016 and issues discussed included incident reporting, health and safety and infection control.

There was a system in place to identify specific hazards relating to the centre and complete risk assessments, where required. However, the process for undertaking risk assessments required improvement. In particular, the calculation of whether a hazard was at a high, medium or low risk was not always accurate, which in turn affected the priority given to specific risks.

Improvements were required in relation to the management of falls. For a resident with a history of falls, assessments were not up-to-date. For example, the 'test for gait and balance' was dated 2012 and the 'screen for fall or risk of falling' was dated 2013. In addition, the 'screen for fall or risk of falling' assessed areas such as neurological function and muscle strength but had been completed by the key worker without input from a professional(s) competent to assess these areas. There was no care plan for falls management in the same resident's file and no risk assessment for falls. It was not clear what the current falls prevention plan was for this resident who had had three falls between September and December 2015.

During this inspection the main fire safety installations of fire alarm panel, emergency lighting and fire extinguishers were all within their statutory inspection schedules with all relevant certificates available on site. The centre had recently been upgraded to take account of fire safety precautions including the availability of emergency lighting throughout. However, a number of fire doors were observed by inspectors to be wedged open with door stops, thus limiting the effectiveness of the fire doors in the event of a fire. This risk had not been adequately accounted for in the centre's risk assessment and controls to ensure fire doors were not wedged open had not been considered.

There were regular fire evacuation drills being undertaken involving the residents and the records of these drills indicated that it had taken between 30 seconds and three minutes to evacuate the premises in drills. Each resident had a personal emergency evacuation plan in place which indicated what supports, if any, residents needed to leave the building in the event of a fire. However, it was not demonstrated that for residents with a hearing impairment that it had been considered whether alternative options to alert a resident in the event of a fire were required. One resident told inspectors that staff had to alert her when she needed to evacuate in the event of a practice fire drill.

There was an emergency plan available which outlined the plan for things like an evacuation, power cut or flooding.

With respect to the prevention and control of infection, the centre followed the Health Service Executive (HSE) information booklet for Community Disability Services (2012). The centre was visibly clean with arrangements in place in relation to cleaning and laundry management, such as colour-coded systems. Facilities were available for hand hygiene. Personal protective equipment was available. However, improvements were required in relation to the arrangements in place for the prevention and control of

Healthcare-Associated Infections. There was no infection control policy or procedure in the centre that outlined what arrangements were in place to prevent and manage infectious diseases in the centre, for example, what training staff required and what records staff were expected to complete with respect to cleaning. While the person in charge described that there were a number of hand hygiene auditors within the service, records of hand hygiene audits or competency assessments were not maintained in the centre. According to training records, most staff had not received training in hand hygiene, infection control or food safety - of 21 training records viewed, only two staff had received training in hand hygiene, one in infection prevention and control and one in food safety.

Systems were in place to ensure that all vehicles used to transport residents were roadworthy, regularly serviced, taxed and insured. Inspectors reviewed a sample of daily checks that were completed for vehicles. Tax and insurance certificates were up to date for all vehicles assigned to the centre. Servicing records evidenced regular servicing of vehicles.

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):

No actions were required from the previous inspection.

Findings:

Residents told inspectors that they felt safe in the centre and that they knew who to report any concerns to in the event of an incident occurring. However, as previously mentioned under Outcome 1, a resident in a questionnaire to HIQA said when another resident displayed behaviours that may challenge, they would not feel safe. Staff interactions with residents were observed to be appropriate and supportive.

The organisation had a local procedure in place for the prevention, detection and response to abuse. Staff were aware of the procedure and the steps to follow in the event of an allegation, suspicion or incident of abuse.

Inspectors assessed the systems in place in the organisation to manage incidents or allegations of abuse. Overall, the systems in place to manage incidents or allegations of

abuse, including those between peers, were managed in a comprehensive way with due consideration of all involved. Multidisciplinary input was available. External supports were sought as required. However, one area required improvement. It was not demonstrated that all recommendations arising from multidisciplinary case conferences were either completed or where it was determined action was not required, how this was agreed and documented.

There was a policy in place for the provision of personal intimate care. In each resident's personal plan was an individual support plan for personal intimate care.

Residents had access to behavioural therapy, psychology and psychiatry as required.

Inspectors reviewed a sample of behaviour support plans and found that they were inconsistent. While some newer behaviour support plans were detailed and provided sufficient guidance for staff, others were not. The person in charge told inspectors that they were progressing rolling out the new format of behaviour support plans. These newer plans included additional key information to support residents to manage their own behaviours that may challenge, such as the function of the behaviour, a communication assessment, the importance of personal space to the resident and positive programs such as independent living skills and communication supports.

Inspectors reviewed a sample of records in the centre pertaining to the day-to-day management of residents' monies. Receipts viewed were signed by two staff. Balances on logs matched the actual balances in the account. However, the person in charge told inspectors that there was no auditing of finances.

All 19 staff had received training in understanding and reporting abuse. However, according to training records, 11 of 19 staff required training in relation to the management of behaviours that may challenge, as required by the Regulations and one staff required refresher training.

Judgment:

Non Compliant - Moderate

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:

Residents had access to healthcare services. Each resident had a comprehensive health assessment and defined health goals. Goals were specific and clearly identified any required healthcare checks, appointments or referrals.

Residents had access to a general practitioner (GP), an out-of-hours GP service and consultants as required such as cardiology, ophthalmology and endocrinology. Residents were supported by a visiting consultant psychiatrist and a consultant neurologist in a neurology outreach clinic. Referrals and reports were maintained in residents' files. It was noted that streamlining of such information was required in that very old information was retained, which was not in line with the organisation's records policy.

Residents had access to allied health professionals including occupational therapy, dietetics and speech and language therapy (SALT) for the meeting of nutritional needs or to manage swallowing difficulties. The accessing of SALT services for supporting residents' communication needs was previously discussed under Outcome 2.

In relation to hospital admissions, the service had developed a hospital communication "passport" for each resident. This "passport" included up to date relevant information about the resident so that hospital staff were aware of any relevant healthcare information, how the resident communicated and their likes/dislikes. There was also a section at the back of the "passport" that could be updated after each admission so that a comprehensive history of the resident's admissions to hospital was available. One of the residents had recently returned to the centre following an operation in hospital and the instructions from the transfer letter from the consultant had been included as part of the resident's plan of care.

Meals during the week were provided by the day service and prepared in the centre at weekends. Breakfast and tea was prepared in the centre and residents were involved in meal choices and preparing snacks and light meals for themselves. It was noted that many foods (such as meat and vegetables) were ordered in bulk from the central kitchen, reducing residents' involvement in shopping for themselves. Staff told inspectors that ingredients for snacks and light meals were bought by residents themselves in the local shop with staff support.

Each house had a separate kitchen, which was clean and fridges and cupboards were well-stocked with fresh fruit, vegetables, meat and dairy products. Sample tea menus were available on display in kitchens. A monthly menu record was maintained. The order book demonstrated that a balanced meal was prepared at weekends.

Where residents were on special diets, specialist input had been obtained from a speech and language therapist (SALT). A folder was kept in the kitchen outlining SALT recommendations in an accessible format.

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 an policy on medication management that was within its review date. The person in charge was also a registered nurse prescriber which meant she could prescribe medication within her scope of practice.

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. The person in charge outlined the pharmacy transcribed the prescriptions for all medication.

It was not always clearly demonstrated that medication was given as prescribed. In one record, the timing for administering the medication had been changed on the prescription sheet from 08:00 to 10:00 but it wasn't clear who had changed the timing of administration.

Where residents received PRN ("as required") medication, there was a PRN protocol in place for that medication. From the sample reviewed, PRN was carefully recorded by staff and monitoring and oversight was demonstrated. Any side-effects from the administration of PRN were recorded. For residents who had a behaviour support plan, oversight of the management of PRN was demonstrated. However, one area was identified that required improvement and this related to the guidance contained in a resident's PRN protocol to clarify at what point PRN medication should be administered.

Some medication needed to be stored in a medication fridge. However, the temperatures on the medication fridge were not being recorded daily and therefore the stability of the stored medication could not be guaranteed.

Judgment:

Non Compliant - Moderate

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 provider nominee of the centre is a qualified nurse in intellectual disability nursing and holds a diploma in personnel management and a post graduate diploma in multiple and complex disabilities. The person in charge is a qualified nurse in intellectual disability nursing, holds a BSc (Nursing) and is also a nurse prescriber. There were two clinical nurse managers (at CNM2 grade) identified as persons participating in the management of the centre in the centre's statement of purpose, one CNM was on night duty and the other CNM on day duty. There were two 'house parents' allocated to the centre.

The person in charge was responsible for this centre and three other designated centres. This centre alone comprised six semi-detached interlinking houses (making up three identifiable units) and one individual stand-alone community house. The total capacity of this centre was 33. The combined capacity of the other three centres for which the person in charge currently has a remit was 45. Given the extensive remit of the person in charge, it was not demonstrated that the arrangements in place could ensure the effective governance, operational management and administration of the designated centres concerned by the person in charge. This was evidenced over the course of the inspection by the number of non-compliances identified in this report.

As a result, inspectors did not proceed with the planned 18-outcome inspection that was originally scheduled to inform the registration of this centre. The provider was requested to submit a proposal to HIQA with respect to ensuring the effective governance and management of the centre both with respect to reviewing the remit of the person in charge and reducing the size of the designated centre itself. A monitoring inspection was completed instead.

It was not clearly demonstrated how staff were facilitated to collectively discuss and review the quality and safety of care and support provided to residents as formal staff meetings did not take place.

The provider had completed unannounced visits to the designated centre. Inspectors reviewed the report arising from such visits and found that visits required development in order to meet the requirements of the Regulations. While some key aspects of quality and safety of care being delivered were reviewed, other aspects were not nor were failings identified on this inspection considered. For example, the adequacy of staffing levels to facilitate residents' activities was not considered, the absence of formal staff meetings was not identified, the inadequate arrangements in relation to the person in charge were not considered and failings relating to the review of the personal plan and transition planning were also not identified.

While the provider had completed an annual review of the centre, the annual review did not meet the requirements of the Regulations as it did not demonstrate that care and support was in accordance with standards. For example, only a sample of units that comprise this centre were included in the annual review.

Arrangements in place did not indicate that the designated centre as it was arranged functioned as a single centre. For example, practices across a number of units within the centre were inconsistent, for example with respect to the management of complaints and the use of communication passports. Provider visits were completed for each unit separately. The annual review only considered two of the four units.

Judgment:
Non Compliant - Major

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):

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

Findings:

As previously mentioned, staffing arrangements at times limited residents' choice in relation to whether or not to participate in activities and options to pursue their individual interests.

There was one volunteer in the centre who received supervision and vetting appropriate to their role and level of involvement in the centre.

A sample of staff files were reviewed. Staff files demonstrated that most of the requirements of Schedule 2 were met. Some omissions were noted as required for completion of the centre's own records, such as commencement dates, work performed and number of hours worked per week.

Not all mandatory training or training required to meet residents' needs was completed as required by the Regulations. As previously mentioned, 7 of 19 staff required training in relation to the management of behaviour that challenges and one further staff member required refresher training. Three of 19 staff required fire safety training and five further staff required refresher training. Ten of 19 staff had not received training in safe 'person moving and handling' and one further staff member required refresher training. Other gaps were noted with respect to medication management, hand hygiene and food safety training and refresher training.

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):

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

Findings:

The management of healthcare records required improvement.

There were two sets of resident records, the person-centred planning folder and a separate file for medical records (described in the centre records management policy as the "active file"). The social care aspect of the person's life were contained in the person-centred planning folder and this is discussed in more detail in Outcome 5. However, it also contained healthcare information and included: an annual health check form, completed by staff with the resident; healthcare assessments; a summary of interdisciplinary support received and; recording of weight and blood pressure, if required.

The person-centred planning folders also contained some recent medical information, including appointment letters, care plans and records of reviews by allied health professionals. These folders also contained records of appointments the person may have had with for example the dentist, chiropodist etc.

The person-centred planning folders also contained some recent medical information, including appointment letters and in-patient admission offers. The remainder of the medical correspondence and healthcare information was kept in the active file described above. This active file contained mainly historical information, for example there was a case conference report for one person dating back to 1995. However, the active folder did contain a lot of current information that was loosely filed at the back of the folder in the inside pocket. In one case a day ward appointment notice for January 2016 was mixed in with blood reports from 2013-2015, consent for a influenza vaccine from November 2015, a contract of care (Appendix 2 of which had become detached from the contract) and a fit to return to work certificate for the resident from September 2015. This filing system could not guarantee the security of healthcare information.

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:

Julie Hennessy
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-0003695
Date of Inspection:	26 January 2016
Date of response:	01 March 2016

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:

Residents were not always afforded the opportunity or assistance to provide consent and making decisions about their care and support. In some circumstances, parents provided consent for residents in relation to the provision of intimate care and administration of medicines.

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

1. Action Required:

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

Each resident in accordance with his or her wishes, age and nature of his or her disability, will be provided with the necessary support to participate in and consent to decisions about his or her care and support. This will be documented in the resident's personal plan.

Proposed Timescale: 31/03/2016

Theme: Individualised Supports and Care

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

Not all practices facilitated independence or choice:

Some plans and programmes that were required were not in place to support individual resident's to make healthy choices, form and maintain healthy personal relationships or manage personal finances, in accordance with their abilities and wishes.

2. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

Residents will be supported to exercise choice and control in his or her daily life. This will be actioned through the participation of each individual in their personal plan review. The PIC will plan rosters that facilitate residents to be supported where necessary to have individual choices met in as far as is practicable through the utilisation of volunteers.

Proposed Timescale: 30/04/2016

Theme: Individualised Supports and Care

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

As outlined in the findings, residents shared bedrooms and were not always happy with who they shared with.

In addition, there was no privacy screening in shared bedrooms.

3. Action Required:

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

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:

In the situations where residents share bedrooms there will be consultation with residents to ensure they are happy with whom they are sharing. In situations where a resident indicates they are not happy to share with another named resident all efforts will be made to seek the resident's preference and to respond to their wishes. All residents' views will be sought where possible and where necessary residents will be provided with the appropriate support to make choices. This process outcome will be documented as part of the resident's personal plan. Funding will be sought to purchase privacy screening.

Proposed Timescale: 31/03/2016

Theme: Individualised Supports and Care

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

As outlined under outcome 17 and this outcome, it was not demonstrated that staffing levels facilitated residents' choices and activities. Residents had made a number of complaints in this regard.

4. Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

The Provider will review the current staffing levels to ascertain the required level to meet the needs highlighted in this report. The PIC will plan rosters that facilitate residents to be supported where necessary to have individual choices met in as far as is practicable through the utilisation of volunteers.

Proposed Timescale: 30/04/2016

Theme: Individualised Supports and Care

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

Relatives were not clear how to appeal the outcome of a complaint if they were not satisfied with that outcome.

As detailed within the findings, the complaints log did not consistently demonstrate that complainants were informed promptly of the outcome of their complaints.

5. Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

The appeals process in the complaints policy will be reviewed in order to include an appeals process with named individual to appeal to in the event the complainant is not satisfied with the outcome of their complaint. The Provider will highlight to all staff the necessity to ensure complainants are informed promptly of the outcome of their complaint.

Proposed Timescale: 31/03/2016

Theme: Individualised Supports and Care

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

The complaints procedure did not identify a second person to oversee how complaints were managed, as required by the Regulations and as a result, the appeals process was not clear.

6. 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 appeals process in the complaints policy will be reviewed in order to include an appeals process with named individual to appeal to in the event the complainant is not satisfied with the outcome of their complaint.

Proposed Timescale: 31/03/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

It was not demonstrated that options available to support all residents to communicate had been adequately explored. Not all residents had a 'communication passport' that passed on key information about how an individual communicates and understands. Some residents with communication needs did not have a communication passport and inspectors found that information contained in their communication profiles in relation to how staff should communicate with residents was broad in nature and where a resident used an iPad and a communication app this was not included in their profile.

For those same residents, there were no communication care plans and no evidence of specialist input with respect to consideration of the use of assistive technologies or devices.

7. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

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

Each resident who has communication needs will have a communication assessment as part of their personal plan. The assessment will include the identification of the necessary supports to assist communication to include assistive technology. Information got from the assessment and plan will be used to provide a communication passport for the individual.

Proposed Timescale: 30/04/2016

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:

Where the centre did not meet residents' needs or abilities, alternatives and options were not being planned or discussed. The person in charge identified a number of residents who could be more suited to living either more independently or alternatively, in an environment with increased supports. As a result, the suitability of the centre to meet the needs or abilities of residents' was not being assessed, reviewed and alternatives pursued in a planned way with the multi-disciplinary team. For example, for a resident who currently presents with increasing healthcare needs, there was no plan in place to meet their changing needs and circumstances.

8. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

A schedule of review of each residents plan will be created & planned. The review of each individual's personal plan will include the following:

- The suitability of the residents living accommodation as per their wishes but also as per their assessed needs
- Multidisciplinary input

The review will identify situations for the individual where the designated centre is not able to meet the resident's needs currently or the review will indicate if the designated centre will be unable to meet the resident's needs in the future.

The review will inform the planning needs for the future for each individual. All outcomes of the review will be clearly documented in the resident's personal plan and

outcomes will be communicated to the resident and their relatives.

Proposed Timescale: 31/05/2016

Theme: Effective Services

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

As detailed within the findings, residents' goals were not based on a comprehensive assessment of resident's needs, abilities and wishes.

9. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

A schedule of reviews will be completed of each residents personal plan. The review will include a comprehensive assessment of each residents needs, abilities and wishes.

Proposed Timescale: 31/05/2016

Theme: Effective Services

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

There was no formal process in place to review the personal plan annually or more frequently if there is a change in needs or circumstances. As a result, the link between personal planning and the care and support required by residents was not demonstrated.

10. Action Required:

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

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

The review of each individuals personal plan will include the participation of the multidisciplinary team members as required.

Proposed Timescale: 31/05/2016

Theme: Effective Services

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

There was no formal process in place to ensure that the review of the personal plan

was multidisciplinary. As detailed with the findings, the impact of failings regarding the multidisciplinary review of the personal plan was evident in a number of ways.

11. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

The review of each individuals personal plan will include the participation of the multidisciplinary team members as required.

Proposed Timescale: 31/05/2016

Theme: Effective Services

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

As there was no formal personal plan review, a process was not in place to allow for reviews to be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability. When asked, a number of relatives told inspectors that they would welcome the opportunity to participate in such a review.

12. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

A schedule of reviews will be created. The review will be conducted in a manner that ensures the maximum participation of each resident and where appropriate his or her representative. The residents wishes will be ascertained in as far as is practical with regard to the nature of his or her disability.

Proposed Timescale: 31/05/2016

Theme: Effective Services

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

It was not demonstrated that discharges from the centre took place in a planned and/or safe manner.

13. Action Required:

Under Regulation 25 (4) (b) you are required to: Discharge residents from the

designated centre in a planned and safe manner.

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

Any discharge of a resident in the future will be planned, in situations other than where an immediate crisis indicates that discharge is necessary for the safety and protection of the resident/other residents.

Proposed Timescale: Completed

Proposed Timescale: 09/03/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The process for undertaking risk assessments required improvement. In particular, the calculation of whether a hazard was at a high, medium or low risk was not always accurate.

14. 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:

The provider will ensure that training is provided to staff to enable the appropriate differentiation of low, medium or high risk. A system will be put in place to respond to any risks that are identified. Risks that are identified will be rated as low, medium or high risk and controls will be put in place to manage the risk. The system will include how emergencies will be responded to.

Proposed Timescale: Places have been booked for 2 staff to attend each of the following Risk Assessment Training Courses:

March:	22nd & 24th
April:	26th & 28th
May:	26th
June:	28th & 30th

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

As detailed within the findings, improvements were required in relation to the

management of falls.

15. 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:

A system will be put in place to respond to any risks that are identified. Risks that are identified will be assessed and rated as low, medium or high risk and controls put in place to manage the risk. The system will include how emergencies will be responded to.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

As detailed within the findings, it was not demonstrated that the system in place for the prevention and control of healthcare associated infections was robust.

16. Action Required:

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

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

The Provider and PIC will review the system in place for the prevention and control of healthcare associated infections. Hand hygiene records and cleaning schedules will be maintained in each residence.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

A number of fire doors were observed by inspectors to be wedged open with door stops, thus limiting the effectiveness of the fire doors in the event of a fire. This risk had not been adequately accounted for in the centre's risk assessment and controls to ensure fire doors were not wedged open had not been considered.

17. 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:

All wedges that were used to fire doors have been removed. A risk assessment has been completed

Proposed Timescale: Complete

Proposed Timescale: 09/03/2016

Theme: Effective Services

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

It was not demonstrated that for residents with a hearing impairment that it had been considered whether alternative options to alert a resident in the event of a fire were required.

18. Action Required:

Under Regulation 28 (3) (b) you are required to: Make adequate arrangements for giving warning of fires.

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

The provider will investigate alternative measures that might be suitable to alert individuals with hearing deficit in the event of a fire.

Proposed Timescale: 31/03/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Improvements were required to ensure that every effort to identify and alleviate the cause of residents' behaviour was made. As detailed with the findings, behaviour support plans were inconsistent.

19. 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:

Where a resident engages in behaviour that challenges, every effort will be made to identify and to alleviate the cause of the behaviour. Behaviour support plans will be reviewed as part of the individual's personal plan and reviewed regularly as required but

at least annually.

Should a restrictive intervention be required, it will be the least restrictive intervention and for the shortest duration having exhausted all alternative measures.

Proposed Timescale: 30/04/2016

Theme: Safe Services

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

While it was evidenced that any incident, allegation or suspicion of abuse was investigated, improvement was required to demonstrate that all agreed actions were completed or where it was later determined that recommended actions were not required, that the rationale for same and decision-making process was clearly documented.

20. 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:

The case conference structure will be reviewed to look at a system to ensure that all agreed actions are completed. This will address situations where there is a waiting period identified before a support such as input by a therapist is delivered

Proposed Timescale: 31/03/2016

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:

For residents who had a behaviour support plan, the guidance contained in a resident's PRN protocol did not provide sufficiently clear guidance for staff to follow in relation to the point at which PRN medication should be administered.

21. 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:

For residents who have a behaviour support plan, the PRN protocols will be audited in consultation with their GP and/or psychiatrist to ensure the protocol provides clear

guidance for staff to follow in relation to the point at which PRN medication should be administered

Proposed Timescale: 31/03/2016

Theme: Health and Development

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

It was not always clearly demonstrated that medication was given as prescribed. In one record, the timing for administering the medication had been changed on the prescription sheet from 08:00 to 10:00 but it wasn't clear who had changed the timing of administration.

22. 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:

The PIC will audit medication management practices and put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines. The audit will pay particular attention to determining how such incidences of prescription time changes are in keeping with guidance and best practice.

Proposed Timescale: 31/03/2016

Theme: Health and Development

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

Some medication needed to be stored in a medication fridge. However, the temperatures on the medication fridge were not being recorded daily and therefore the stability of the stored medication could not be guaranteed.

23. 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:

The practice for the storage of medication that requires refrigeration will be reviewed. This will include the introduction of recording to ensure the daily temperature is compatible with suitable and safe storage of medication that requires storage in a

fridge.

Proposed Timescale: Completed

Proposed Timescale: 09/03/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The person in charge was responsible for this centre and three other designated centres. Given the extensive remit of the person in charge, it was not demonstrated that the arrangements in place could ensure the effective governance, operational management and administration of the designated centres concerned by the person in charge.

24. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

The designated centre has been reconfigured. One residence has been removed from the designated centre and subsequently from the operational management of the PIC. This centre (that has been removed) has two respite beds and therefore has a large number of persons availing of the service, resulting in a large number of personal plans that require regular review. This will significantly reduce demands on the PIC. In order to support the PIC at the designated centre the Provider will meet the PIC monthly in order to identify priority issues to be addressed. A PPIM with excellent knowledge of the designated centre will be in place by 21/03/2016. The Provider is assured that these measures will ensure the effective governance at Cork City 1.

Proposed Timescale: 21/03/2016

Theme: Leadership, Governance and Management

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

As detailed within the findings, it was not demonstrated that the management systems in place in the designated centre ensured that the service provided was effectively monitored.

25. 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:

The designated centre has been reconfigured. One residence has been removed from the designated centre and subsequently from the operational management of the PIC. This centre (that has been removed) has two respite beds and therefore has a large number of persons availing of the service, resulting in a large number of personal plans that require regular review. This will significantly reduce demands on the PIC. In order to support the PIC at the designated centre the Provider will meet the PIC monthly in order to identify priority issues to be addressed. A PPIM with excellent knowledge of the designated centre will be in place by 21/03/2016. The Provider is assured that these measures will ensure the effective governance at Cork City 1.

Proposed Timescale: 21/03/2016

Theme: Leadership, Governance and Management

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

While the provider had completed an annual review of the centre, the annual review did not meet the requirements of the Regulations as it did not demonstrate that care and support was in accordance with standards.

26. 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 provider will revisit the annual review to ensure that the care and support at the designated centre is in accordance with the standards

Proposed Timescale: 30/04/2016

Theme: Leadership, Governance and Management

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

While the provider nominee had completed unannounced visits to the designated centre, it was not demonstrated that the visits considered in a comprehensive manner the safety and quality of care provided in the centre, as necessary to ensure that any plan in place would be able to address any concerns regarding the standard of care and support.

27. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the

designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

The provider will continue to carry out unannounced visits to the designated centre at least every six months or more frequently. The visits will continue to be documented but will include a more comprehensive report on the safety and quality of care and support provided in the centre. The provider will put in place a plan to address any concerns that are identified in the report.

Proposed Timescale: 30/04/2016

Theme: Leadership, Governance and Management

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

It was not clearly demonstrated how staff were facilitated to collectively discuss and review the quality and safety of care and support provided to residents as formal staff meetings did not take place.

28. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

The PIC will put in place a schedule of formal staff meetings in order to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Proposed Timescale: Schedule completed.

Proposed Timescale: 09/03/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Not all mandatory training or training required to meet residents' needs was completed as required by the Regulations. As previously mentioned, 7 of 19 staff required training in relation to the management of behaviour that challenges and one further staff member required refresher training. Three of 19 staff required fire safety training and five further staff required refresher training. Ten of 19 staff had not received training in

safe 'person moving and handling' and one further staff member required refresher training. Other gaps were noted with respect to medication management, hand hygiene and food safety training and refresher training.

29. 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:

Staff training will be reviewed and a plan put in place to ensure staff have completed mandatory training, including refresher training in the management of behaviour that challenges, fire safety training, person moving and handling, medication management, hand hygiene and food safety

Proposed Timescale: Training plan /schedule in place

Proposed Timescale: 09/03/2016

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 management of healthcare records required improvement.

30. 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:

The PIC will ensure the regular auditing of healthcare records

Proposed Timescale: Commenced

Proposed Timescale:

