Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 22
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	30 January 2023
Centre ID:	OSV-0007986
Fieldwork ID:	MON-0032657

About the designated centre

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

This designated centre is located on the north side of a large city. It is home to two female residents. The services provided is full-time residential care for people with intellectual disability and autism. Each resident has a single bedroom and separate living room. The centre also comprises of a hallway, bathroom, kitchen dining area, a staff office and staff water closet. There is a front and rear garden with a ramp to assist access. The staff team comprises of a clinical nurse manager 2 as the person in charge and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 30 January 2023	11:30hrs to 18:30hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed, residents in this centre were seen to be happy in their home and were well cared for by a committed staff team. Some issues in relation staffing meant that one residents' access to the community was impacted. Issues in relation to fire safety procedures were also noted on this inspection.

The centre comprised of a single story two bedroom house located in a residential area of a large city. The centre was observed to be clean, bright and airy and residents' bedrooms were personalised and nicely presented according to their preferences. Numerous photographs of residents and their family and friends were on display.

Two young women lived in this centre. The inspector had an opportunity to meet with both residents on the day of this inspection. The inspector adhered to infection control and prevention guidance, including the use of appropriate personal protective equipment (PPE) as required during this inspection. One resident was present with two staff when the inspector arrived to the centre. This resident had recently returned to the centre that morning from a home visit. This resident spoke with the inspector and showed the inspector around their home. They told the inspector about the things they liked to do and communicated that they were happy in their home, felt safe in the centre and liked the staff that supported them. This resident was observed to be busy throughout the day attending to personal care and taking part in activities of their choosing with the support of the staff present.

A second resident returned from day services in the early afternoon. This resident interacted briefly with the inspector but did not communicate verbally with them. They were content to spend some time in the vicinity of the inspector and the inspector observed that they were comfortable and relaxed in their environment, which had been specifically designed to cater for their needs. Staff were seen to support both residents in a dignified and supportive manner that suited their assessed needs and residents were observed to be content in their home and to move about freely in their home.

The inspector observed and heard a number of positive interactions between staff and residents, and throughout the day of the inspection there was a calm and relaxed atmosphere in the centre. One resident liked to listen to music and was supported to do this, with staff changing the music for the resident on occasion based on their known preferences. A resident living in the centre had been supported to celebrate an important occasion on the day of the inspection in their day services, and staff were heard to greet the resident with reference to this on their return to the centre.

The inspector saw that a resident had the use of a room that was laid out with equipment and lighting to cater for their sensory preferences. Staff were noted to regularly interact with this resident and this resident had a limited selection of

activities available to them. It was reported that this resident enjoyed walking and being outside and regularly went walking with family members. However, as will be discussed in the next section of this report, this resident usually remained in the centre building on their return from day services in the early afternoon due to staffing levels in the house.

Although the general care and support of residents was observed to be good on the day of this inspection, there was non compliance with a number of the regulations and this meant that residents were not always being afforded safe and person centred services that met their assessed needs. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service.

Capacity and capability

This centre is run by COPE Foundation. Due to concerns in relation to Regulation 23 Governance and Management, Regulation 15 Staffing, Regulation 16 Training and Staff development, Regulation 5 Individualised assessments and personal plan and Regulation 9 Residents' rights, the Chief Inspector is undertaking a targeted inspection programme in the provider's registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in October 2022 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan the provider has provided an action plan to the Chief Inspector highlighting the steps the provider will take to improve compliance in the providers registered centres. These regulations were reviewed on this inspection and this inspection report will outline the findings found on inspection.

There was a clear management structure present in this centre. However, the inspector found on the day of this inspection that the governance and management systems in place had not ensured that the services provided within the centre were at all times in compliance with the regulations. Staff resources in place were not ensuring that the services provided within the centre were at all times meeting the assessed needs of one of the residents that lived there.

The person in charge was not present on the day of this inspection. The person nominated to participate in the management of this centre was also unavailable. The statement of purpose set out that a CNM1 would also provide support to the person in charge in the management of this centre. The person appointed to this role was on long term leave at the time of the inspection and the provider were in the process of recruiting an individual for this vacancy. Staff had the support of an on-call member of senior management at night and at times when a member of the centre's local management team was unavailable. A representative of the provider, a regional manager in another area who had some knowledge of the centre, facilitated

the inspector during the inspection and provided additional documentation as requested. Feedback was provided to this individual at the end of the inspection.

The person in charge of this centre had a large remit, with responsibility for four designated centres at the times of this inspection. A report prepared about the providers most recent six monthly unannounced visit had identified that the person in charge did not have capacity to ensure full oversight of this designated centre, given their remit. The statement of purpose set out that the person in charge would spend at least eight hours per week in this centre. Although records viewed in the centre indicated that the person in charge had visited the centre at least 4 times in the previous month, these visits were generally one to two hours in duration. However, it was seen that the documentation in the centre was well managed and maintained and overall there was evidence of improvements in oversight in the period prior to this inspection. The inspector saw that an experienced, core staff team in place reduced the impact this was having on residents. However, there was some evidence that oversight wasn't fully maintained due to the remit of the person in charge. A number of actions from the previous six monthly audit in August 2022 remained outstanding. For example, no fire drill had been carried out since this centre had opened and some staff supervisions were overdue. The inspector sought assurances in relation to the fire evacuation procedures and was informed that a successful fire drill was completed following the inspection.

Two staff were present in the centre on the day of the inspection and the inspector met with both of these staff. These staff were very knowledgeable about residents and their support needs and were observed to provide high quality person centred supports to the residents on the day of the inspection. Staff were familiar with the documentation and the procedures in the centre and it was observed that the regular staff in the centre maintained a level of oversight of the day-to-day running of the centre in the absence of the person in charge.

A staff rota was viewed in the centre. This set out the planned staffing arrangements for the centre but did not include the names of agency staff members that worked in the centre. Usually, at least one agency staff member worked in this centre four or five nights a week. An actual staff rota, detailing any changes to this planned rota that had occurred was not present in the centre. The inspector was told that this would be kept in an external location where the person in charge had an office. Daily fire safety documentation had been completed that laid out the staffing arrangements in place on a given day and these were made available to the inspector. The centre was seen to overall be staffed by a committed staff team and there was clear evidence that efforts were made to maintain consistency of the staff team for residents and to minimise the impact of staff vacancies on residents. For example, if required, familiar agency staff provided supports to residents and if possible at least one familiar staff member was on duty at all times.

The statement of purpose set out the minimum staffing arrangements for this centre. This set out that when both residents were present in the centre there should be two staff by day, and two waking staff by night. Records viewed showed that these staffing levels were not always maintained. Sometimes, a lone staff member would support both residents. It was seen that this usually occurred at

night, although occasionally this would occur by day also. The inspector also saw documentation, such as a risk assessment, that set out that one resident required 2:1 staffing to leave the centre. There were no arrangements in place to provide two dedicated staff for this resident while they were in the centre, and the statement of purpose did not reflect how this staffing would be provided to this resident. This meant that usually this resident could not leave the centre unless they were going home or attending their day service. A staff member told the inspector that some familiar staff were able to support this resident to go for walks on a 1:1 basis. However, this was not reflected in the risk assessments in place for this individual. Also, the inspector was told that this resident enjoyed using the backyard area of the centre but the risk assessment in place around this indicated that two staff were also required for the resident to spend time in the yard of the centre and it was not clear how the resident was to be supported with this in the event that both residents were present in the centre. Incident logs were viewed on inspection that showed a near-miss incident had occurred while this resident was outside unattended.

The person in charge had maintained clear records of the training provided to staff in the centre. The inspector saw that, on the whole, appropriate staff training was provided in this centre. The providers six monthly audit of the centre indicated that staff supervisions were not always occurring in line with the provider's policy. However, at the time of this inspection, the inspector saw evidence that this issue was being addressed. The inspector requested details about the training that was completed by agency staff members prior to working in the centre, and assurances were provided by the provider in relation to this.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

A planned staff rota was viewed but the actual staff rota was not available on the day of the inspection. Documentation in the centre showed that staffing levels were not always maintained as per the statement of purpose. However, even when they were, staffing in the centre was not adequate to meet the assessed needs of residents at all times. For example, one resident required the support of two staff to leave the centre, but usually only two staff were rostered to work in the centre when both residents were present, and at times a lone staff member supported both residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Overall, the person in charge had ensured that staff had access to appropriate training, including refresher training. Although some staff were overdue training in positive behaviour support and one staff members fire safety training was out of date, these training sessions had been booked for the period following the inspection. Some staff supervisions had not occurred in line with the provider's policy but there was evidence that this was being addressed at the time of this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

A clearly defined management structure was in place in the designated centre and management systems such as auditing schedules were in place. There was some evidence that oversight wasn't fully maintained in this centre. For example, no fire drill had been carried out since this centre had opened and some staff supervisions were overdue. The provider had identified that the remit of the person in charge was too large in the most recent six monthly audit. The supports available to the person in charge were also impacted by an unfilled vacancy in the local management team.

Judgment: Not compliant

Quality and safety

The wellbeing and welfare of residents was overall maintained by a good standard of evidence-based care and support. On the day of this inspection it was seen that overall good quality supports were provided to the residents that lived in this centre by a committed staff team. However, some issues in relation to staffing were impacting on residents' rights and impacting on safe access to the community for one resident. As mentioned in the previous section of this report some assurances were requested from the provider in relation to the fire safety procedures in place in this centre, namely that a fire drill was completed with residents. These assurances were provided following the inspection.

On the whole, residents were seen to be supported in line with their assessed needs and there was an evident person centred culture present in the centre. One resident in this centre was supported to attend various activities and access the community on a regular basis by the staff that supported them in the centre during the day. The inspector saw that efforts had been made to re-introduce this resident to day services in the recent past but that the residents' needs and wishes were being

taken into account in relation to this. The second resident attended day services and both residents visited and spent time with family members on a regular basis. However, while present in the centre, one resident did not regularly access the community.

A number of issues had been identified in the previous six monthly audit of the service and some actions had been completed since that review. However, some issues remained outstanding. One action on the audit was to 'ensure that residents have access to meaningful occupation and activation of choice'. This inspection found that for one resident in particular, staffing levels were not adequate to afford choices in relation to community access. This resident had communication challenges that might present as a barrier to determining some choices. However, they did use communication cues such as body language and facial expressions to communicate their satisfaction and contentment and it was reported that this resident enjoyed attending day services and took part in activities there. The inspector saw that the resident did have a selection of activities available to them in their home, but these were limited. It was noted that a referral had been made for an occupational therapy assessment to provide guidance in relation to sensory activities that this resident might benefit from. This inspection found that this resident did not have regular opportunities to take part in and try activities outside of the centre building once they returned from their day service. Despite the resident reportedly enjoying community access such as walks and bus drives, these activities were not offered on a regular basis to the resident. Where staff did take the resident walking, at times this was not carried out in line with a risk assessment in place.

Personal plans were viewed by the inspector. These were seen to be person centred and were presented in a clear and easy-to-read format. Recent Multidisciplinary reviews had been completed and important information about residents was provided in a clear format to provide guidance to staff. Residents and their representatives had taken part in the person centred planning process and there was evidence of recent person centred planning meetings. Although some goal setting was occurring and some goals were identified for residents, for one resident the short term goals in place required review to ensure that they were meaningful and reflected efforts to maximise the resident's personal development. There was limited documentation in place in relation to the progression or completion of goals for residents. Deficits in relation to meeting the assessed needs of one resident are covered in this report in the previous section under Regulation 15.

Plans and documentation viewed were seen to take account of residents' cultural and religious practices, and details about this such as specific dietary requirements were clearly identified for staff on residents' plans. Staff had completed training on Human Rights. A number of audits had been completed that were focused on ensuring the privacy and dignity of residents and information on advocacy was available to residents.

Regulation 5: Individual assessment and personal plan

Residents' personal plans were viewed. Documentation in place showed that residents were involved in annual person centred planning meetings and that efforts were made to include family members and people important to the residents in this process. Goals had been identified in these plans but there was not clear evidence of progression, completion and ongoing review of goals. Plans in place did not always outline the supports in place to maximise residents' personal development.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There was a strong focus on resident rights in this centre. Staff were observed to speak to and interact respectfully with residents and the spoke about residents in a manner that was rights focused and staff had completed training on rights. Residents were supported to exercise their rights and residents were seen to have choice and control over aspects of their daily lives. Visual choices were offered to a resident who did not communicate verbally. Staffing levels in the centre were restricting one resident from leaving the centre to access the community and participate in activities in the afternoons and evenings and this was limiting their choices and their right to access ordinary places.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 22 OSV-0007986

Inspection ID: MON-0032657

Date of inspection: 30/01/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Planned staff rosters will be available in the centre each week. As changes arise to the roster the PIC will ensure that staff and residents are informed of same. • Recruitment is ongoing to fill vacant positions that are currently filled by consistent and familiar agency staff. • Risk assessment for lone worker by night will be completed by the PIC to form part of the centres risk register • Recruitment to fill vacancies is ongoing. There should be 9 WTE staff assigned to the centre as per the statement of purpose. Once WTE vacancies are filled the PIC will ensure that rosters are reflective of residents will and preference regarding evening activities offsite. • Once vacancies are filled the SOP will be updated to reflect staffing hours / shift pattern requirements to support residents to take part in external evening activities	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff have now completed fire training and certificates are onsite • Positive behavior support training continues as scheduled with a planned completion date of 1/06/2023 • All outstanding formal supervision meetings have been completed	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Fire drill has been completed since the inspection and a schedule of fire drills is in place	

which is overseen by the PIC • Staff formal supervision meetings have been completed and PIC will ensure to continue to schedule regular individual meetings with staff as part of governance plan • The PICs remit will be decreasing to 3 designated centres in the coming weeks which will allow for increased oversight of this centre • The PIC and PPIM meet bi-weekly at regional meetings and the PIC and PPIM meet on an individual basis monthly or as required. The PPIM is available via telephone to the PIC outside of these scheduled meetings and the PPIM will visit the centre regularly	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Personal plans are reviewed on an on-going basis and will continue to be reviewed as required. • Goal progression and monitoring of same has been discussed with all staff and PIC has oversight of same and assists staff as required to document same appropriately. • PIC will review all personal plans with staff regularly with a view to have same completed including review of individual risk assessments by 30th June 2023.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Recruitment to fill vacancies is ongoing. There should be 9 WTE staff assigned to the centre as per the statement of purpose. Once WTE vacancies are filled the PIC will ensure that rosters are reflective of residents will and preference regarding evening activities offsite. • Once vacancies are filled the SOP will be updated to reflect staffing hours / shift pattern requirements to support residents to take part in external evening activities	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/07/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	05/07/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent	Not Compliant	Orange	31/07/2023

	and effectively monitored.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/06/2023
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/06/2023
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	31/07/2023