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:	West County Cork 6
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	14 February 2023
Centre ID:	OSV-0003716
Fieldwork ID:	MON-0035004

About the designated centre

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

This centre is located in West Cork. It is in a location with access to local shops, transport and amenities. The service is managed by COPE Foundation Ltd and comprises of a purpose-built 10 bedded ground floor house. This centre was set up to provide a specialist service for persons with an intellectual disability. The centre supports residents to live a meaningful everyday life. Each individual is assessed, and a plan put in place to meet their needs. The assisted living model provided in this home, is a flexible response to individuals, some with complex needs including autism. As residents' needs change over time, the resident's plan of care is adapted with appropriate support provided by staff. The emphasis, in this centre, is on independent living, community integration and appropriate support as residents' needs change. The ethos in this centre is to provide a welcoming, homelike and friendly environment which affords comfort and safety to residents, staff and significant others. The service is provided Monday to Friday with staff support both by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Tuesday 14 February 2023	09:30hrs to 14:30hrs	Laura O'Sullivan	Lead
Tuesday 14 February 2023	09:30hrs to 14:30hrs	Louise O'Sullivan	Support

What residents told us and what inspectors observed

West County Cork 6 is a designated centre located in a large rural town. The centre at the time of inspection operated a service to a maximum of 9 residents over a period of 4 nights. The centre was currently transitioning to a 7 night service in line with the residents' wishes and their assessed needs. To ensure the change in service provision was completed in a safe and effective manner the staff team was increasing with two staff members completing induction on the day of the inspection. They were also spending time with residents to build relationships and to become aware of their unique and individual needs and supports.

The inspection of the centre was unannounced and completed to monitor ongoing compliance and to ensure adherence to the organisational level service improvement plan. The inspection was facilitated by the residents of the centre, the staff team and the appointed person in charge. All staff present were aware of the service improvement plan and measures which were required to improve overall governance within the organisation. The person in charge through regular staff and resident engagement communicated all updates in a timely manner.

The inspectors had the opportunity to meet and speak with a number of residents on the day of the inspection. On arrival one resident was sitting in the living room waiting to go their day hub. They told the inspector they had started social farming the day before and had received a new hat there. They were planning on going to Special Olympics at weekend and was looking forward to this. They spoke of being happy in the centre but were also excited to move to their new house soon. This resident and two peers were in the planning stages of transitioning to a new house in the community.

A number of other residents were having breakfast in the dining area. The staff present introduced the inspectors to the residents and welcomed them to the centre. The inspectors presented the resident with a Nice to meet document which is utilised to show the residents who is present in their home and what the role of the inspectors was. These were displayed on the notice board for all staff and residents to see.

A resident came to speak with the inspectors when they arrived to the centre. They told the inspector about their planned move to the new house. They had developed a mood board with staff of what colours they wanted their room to be. As an avid Liverpool supporter their room was to be red. This information and other items important to the needs and wishes of the resident was present on the mood board and in their transitional plan.

Residents were observed going about their day in a happy manner. Residents were observed singing going about the centre and laughing with staff. The staff team were interactive with residents and provided support in a respectful and dignified manner. Staff spoken with were very aware of the individual needs of residents and

how to support them in a consistent manner. Residents spoken with spoke highly of the staff team and how happy they were in the centre.

The centre presented as a large purpose built bungalow. Through the use of a "pod" the use of the shared bedroom was kept to a minimum. Every second week a shared room was used for 4 nights. The provider had a plan in place to ensure all residents were supported in single occupancy rooms in line with their wishes. There was evidence this was actively being addressed at the time of inspection with measures in place to ensure the needs of residents was paramount in the interim.

When inspectors were walking through the centre one resident requested to show the inspectors their room. They proudly showed the inspectors their jigsaw collection which they displayed throughout the centre. These were large 1000 piece jigsaws which staff supported the resident to glue, frame and display in their room and in the centre. The resident laughed and joked with staff and inspectors during the conversation and appeared very content in their company. They left the conversation to go bowling with some of their friends in the afternoon.

The next two sections of the report will review evidence present in the areas or capacity and capability of the provider and the quality and safety of the service provided and how this impacts the life of the residents.

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, regulation 5 Individualised assessments and personal plan and regulation 9 Rights , the Chief Inspector of social services is undertaking a targeted inspection programme in the providers 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.

The registered provider had ensured the appointment of a clearly defined management structure to the designated centre. A suitably qualified an experience person in charge reported to the appointed person participating in management. Members of the governance team had an awareness to the current and changing needs of the residents currently residing within the centre. Through regular communication they held an awareness of their role and responsibilities under the Health Act 2007. Regional level manager meetings were held on a fortnightly basis to share learning and to review on concerns or areas identified as requiring

improvement.

The person in charge completed a range of monitoring tools to ensure a safe and effective service was afforded to residents. These included infection control audits, fire safety checks and monthly review of risks. An audit review was in place to ensure all onsite audits were completed and reviewed as required. These were completed in conjunction with the regulatory required annual review of service provision to monitor compliance with standards and to drive service improvement within the centre.

The most recent annual review of service provision review had been completed by the delegated persons in November 2022. This review identified areas of good practice within the centre such as resident consultation. An improvement plan had been developed to complete actions such as a stepped approach to goal setting. This action had been completed. However, a six monthly unannounced visit had not been carried out to the centre since May 2022. This required review to ensure adherence to regulations.

There was an actual and planned roster in place and this was maintained by the person in charge. From a review of the rosters, the inspector observed that there were adequate staffing levels in place in order to meet the needs of the residents. The person in charge had an awareness of the ongoing need for staff review to ensure staffing levels and skill mix was reflective of the assessed needs of residents. A plan was in progress to increase the service of the centre from 4 nights to 7 nights, with the provider having increased staffing resources.

The person in charge had ensured that the staff team allocated to the designated centre were supported and facilitated to access appropriate training. This included areas such as medication management and safeguarding vulnerable adults from abuse. A schedule was in place to identify any training needs and to ensure these were completed in a timely manner. All staff completed a comprehensive induction programme prior to commencing duties within the centre. Two staff were completing this on the day of the inspection.

The person in charge had ensured effective measures were in place for the supervision of staff. For example, Formal annual appraisals were completed in accordance with organisational policy. These had been completed for all staff including the person in charge for 2022. Professional development was one aspect of this to continue to drive service improvement in centre in such areas as communication. Regular staff meetings were completed to ensure staff had an awareness of their role and responsibilities. These included general staff meetings relating to the day to day operations of the centre, but also specific meetings pertaining to such areas as infection control, health and safety and safeguarding.

Regulation 15: Staffing

There was an actual and planned roster in place and this was maintained by the

person in charge. From a review of the rosters, the inspector observed that there were adequate staffing levels in place in order to meet the needs of the residents.

The person in charge had an awareness of the ongoing need for staff review to ensure staffing levels and skill mix was reflective of the assessed needs of residents. Nursing care was afforded to residents as required.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that the staff team allocated to the designated centre were supported and facilitated to access appropriate training. This included such areas as medication management and safeguarding vulnerable adults from abuse.

A schedule was in place to identify any training needs. All staff completed a comprehensive induction programme prior to commencing duties within the centre.

The person in charge had ensured effective measures were in place for the supervision of staff. For example, Formal annual appraisals were completed in accordance with organisational policy.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had ensured the appointment of a clearly defined management structure to the designated centre. Members of the governance team had an awareness to the current and changing needs of the residents currently residing within the centre.

The person in charge completed a range of monitoring tools to ensure a safe and effective service was afforded to residents. These were completed in conjunction with the regulatory required annual review of service provision to monitor compliance with standards and to drive service improvement within the centre.

However, a six monthly unannounced visit had not been carried out to the centre since May 2022. This required review.

Judgment: Substantially compliant

Quality and safety

West County Cork 6 was a designated centre located in a large rural town. The centre at the time of inspection operated a service to a maximum of 9 residents over a period of 4 nights. The centre presented as a warm homely environment. The residents presented as very comfortable and content not only in their environment but in the company of staff.

The centre was operated in a manner which respected the rights of the residents. Measures were undertaken to ensure residents were aware of their rights. These included regular weekly house meetings to discuss the day to day operations of the centre such as meal planning and activities. Keyworker meetings were held with each resident to discuss individual topics such as personal goals and transitioning. The person in charge also met with residents on regular basis to discuss any relevant topics such as safeguarding, privacy and dignity

Residents were supported to advocate on their own behalf or if required the assistance and support of an external advocate was sourced and facilitated. Many policies and procedures had been developed in accessible format to facilitate resident engagement in such areas as complaints and finances. These tools were utilised to ensure resident were supported in choice in their daily lives.

The person in charge had ensured that each resident was support to develop and maintain an individualised personal plan. These plans incorporated an annual multi-disciplinary assessment of each individual's personal needs. Residents were supported to develop personal goals during an annual person centred planning meetings with evidence of progression of these goals in place. Photographs were used to evidence and remember resident participation in goals. Goals incorporated community inclusion and independence skills.

Guidance for staff was laid in a range of areas such as health, social and emotional supports. This ensured a consistent approach to support and adherence to multi-disciplinary guidance. Staff were observed adhering to support plans in place such as communication and eating and drinking. Staff spoke confidently of the support needs of resident and introducing new goals in the local community such as the newly commenced social farming.

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that each resident was support to develop and maintain an individualised personal plan. These plans incorporated an annual multi-disciplinary assessment of each individuals personal needs. Residents were supported to develop personal goals during an annual person centred planning

meetings with evidence of progression of these goals in place.

Guidance for staff was laid in a range of areas such as health, social and emotional supports. This ensured a consistent approach to support and adherence to multi-disciplinary guidance.

Judgment: Compliant

Regulation 9: Residents' rights

The person in charge had ensured that the centre was operated in a manner which respected the rights of all individuals. Residents were consulted in the day to day operations of the centre through keyworker and house meetings.

The person in charge had systems in place to support residents in larger life decisions. Advocacy forums were held to discuss such topics as complaints, safeguarding, and transitioning between services.

Judgment: 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for West County Cork 6 OSV-0003716

Inspection ID: MON-0035004

Date of inspection: 14/02/2023

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: On 16/03/2023 an unannounced visited took place to report on the safety and quality of care and support provided in the centre .The provider will ensure these unannounced visits will take place every 6 months as per regulation.	

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 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall 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 shall 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.	Substantially Compliant	Yellow	16/09/2023