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 18
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	12 April 2023
Centre ID:	OSV-0005628
Fieldwork ID:	MON-0033288

About the designated centre

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

A full-time residential service is provided for adults with an intellectual disability in this designated centre. The centre comprises two bungalows located on a campus in an inner city suburb of a large city. There are two other designated centres comprising five houses and a day service also located on the campus. A maximum of 16 people can live in the centre. On the day of inspection there were seven people living in one bungalow, and eight in the other. Both bungalows were purpose built including accessible bathroom / shower facilities for residents who use mobility aids. The communal spaces in each house included a large sitting room, a spacious sun room, a separate dining room and a kitchen. The staff team was nursing lead and comprised of nursing staff and care assistants. An activities coordinator was employed full-time between the two houses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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
Wednesday 12 April 2023	09:30hrs to 17:00hrs	Kerrie O'Halloran	Lead
Wednesday 12 April 2023	09:30hrs to 17:00hrs	Laura O'Sullivan	Support

What residents told us and what inspectors observed

This was a short term announced inspection to monitor the provider's compliance with the regulations. In addition, to ensuring residents were being supported to have a good quality of life in a safe environment while being supported as per their assessed needs. The designated centre comprises of two bungalow style houses, on a campus setting in Cork city. On the campus there are other designated centres and a day service operated by the provider. Each bungalow contains a kitchen, dining room, living room, conservatory, laundry room and a staff office. One bungalow contains seven bedrooms, a multi-sensory room and a store room, while the other contains nine bedrooms. Each resident had their own bedroom.

From meeting with the residents, and from observing staff interacting with residents it was clear that residents were being supported to enjoy a varied and meaningful life in line with their wishes. The inspectors met with the person in charge and person participating in management during the inspection day, and reviewed documentation about the care and support residents received. It was identified in the opening meeting that one bungalow now had a storage room in place. This was previously an unused bedroom which had been converted. The provider had not notified the chief inspector of a change to the floor plan of the designated centre, which pertains to condition 1 of the designated centres current registration.

On arrival the inspectors visited one of the bungalows and briefly met six residents. These residents were getting ready to go to day services or activities in the community, and were being supported by the staff to prepare for their day. Later in the afternoon, the inspectors met the other residents who lived in the other bungalow in the designated centre. One of the residents, with the support of the staff spoke about going swimming that they go to every week with other residents. This is an activity they really enjoyed. The inspector saw an activities board displayed in picture format of the activities the residents liked to do during the week. These included watching television, listening to music, going to the local beauty salon and going for walks in the community, swimming and the cinema. On the day of the inspection other residents were seen to be supported by staff to go to the cinema and walks. Some residents also attended the day service located on the campus.

The provider had contacted family members as part of the annual review and overall positive feedback was received on the care and support their relatives received from staff in the centre. As part of the review the provider had sought feedback from the residents. Eight residents responded with very positive feedback, for example residents stated that they loved their bedrooms and they felt supported. However, the annual review had identified some issues which will be discussed in the next section of the report. One family member had also stated that when they visited a resident their bedroom was cold.

The residents all appeared happy and comfortable in the centre, and the inspector

observed that the staff interacted with residents in a kind and respectful way. There was a very positive atmosphere in the centre, with residents and staff heard laughing and singing while doing laundry together in the afternoon. The inspector observed staff interacting with the residents consistent with their preferences, and were responsive to requests made by residents. For example, a resident told the inspector they would like another cup of coffee, and this was promptly prepared by a staff member.

The centre was homely and each of the residents had a spacious bedroom, individually decorated with personal items and soft furnishings. One resident proudly showed an inspector their cup collection in their bedroom. Residents had plenty of storage in their own rooms for their personal belongings, however, on a walk-about of the premises the inspector identified wardrobes in two resident's bedrooms that were locked and also storage press in the multi-sensory room. This was highlighted to the staff and person in charge on the day of the inspection, as it had not been submitted to the office of the chief inspector as required by the regulations or present on the restrictive practice log.

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 being delivered.

Capacity and capability

Areas for improvement were found on this inspection relating to the governance and management of the designated centre, staffing, individualised care plans and residents rights. An urgent action was also issued on the day of inspection due to concerns around resident's access to their personal finances and residents privacy in their own living space.

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 of Social Services 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 clearly defined management structure. Staff reported to the person in charge, who reported to the regional manager. A clinical nurse manager 1 (CNM1) was in place to assist the person in charge in their role. An audit schedule was in place for the designated centre, a number of audits had been completed, and the actions which arose following audits were identified within a time line to complete. However these were completed by the CNM1 and there was no documentary evidence available that the person in charge had oversight of these audits and the actions being completed. In addition, the audits had not identified arising issues in the designated centres. For example, an internal audit had not identified a broken window in the kitchen and damage to a kitchen unit in one of the bungalows.

The inspectors spoke to the person in charge and person participating in management regarding the management of supporting resident's privacy, protection from risk of harm, promoting and protecting residents' human rights. While the person in charge and person participating in management were knowledgeable on the current plans in place to support residents, the inspector found staff on duty did not have sufficient knowledge of a current plan in place for a resident and the oversight for sharing this knowledge and identifying risks in a timely manner was not evident on the day. Staff knowledge of such plans in place are important to ensure measures are put in place to ensure consistent and effective support is provided for residents. After the inspection, an inspector contacted the person in charge in relation to an incident that was reported to the centre. It was subsequently indicated that the matter had been reviewed internally by the provider and assurances were given that this was managed by the provider.

As mentioned previously, an annual review of the quality and safety of care and support had been completed. The annual review contained areas for improvement but did not have follow up to address these areas. For example, it was identified the policy on visitors to be reviewed and the health care actions plans for one of the houses also needed to be reviewed. Where a family member had raised a concern as part of the relating to the heat of a bedroom there was also not evidence that this had been followed up on.

Staff in the centre received supervision from the person in charge through supervision meetings. Formal supervision meetings were completed in accordance with the organisational policy and were completed in conjunction with regular team meetings. The registered provider had ensured the number and skill mix of the staff team within the centre was appropriate to the assessed needs of the residents. The person in charge maintained a planned and actual roster in the centre. This roster did not reflect the staff as set out in the statement of purpose. For example, this centre operated with nursing staff in both bungalows, which was reflective of the roster in place and what the inspectors observed on the day of the inspection. However the statement of purpose identified one nursing staff in one bungalow that made up the designated centre. The inspectors reviewed the staff training matrix and saw that all staff mandatory training was up-to-date and were refresher training was required staff had scheduled dates for 2023. All staff had received training in human rights.

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

The statement of purpose and function is a governance document that outlines the service to be provided in the designated centre. The statement of purpose reviewed on the day of the inspection was found to accurately describe the services provided in the centre. However, the current staffing profile for the governance and management of the centre did not reflect the roster on the day of the inspection. The registered provider had not contained an accurate reflection of staffing in place as per Schedule 1.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training, including refresher training when required. A schedule of training for 2023 was also in place. Arrangements were in place for staff to take part in formal supervision.

Judgment: Compliant

Regulation 23: Governance and management

Findings from this inspection did not reflect governance and management at a level that ensured, assured and maximised the provision of a safe and quality service. Systems for review and oversight did not always identify issues or where they did, the learning and plans in place were not always expanded to improve and assure practice across all of the designated centre. These issues and inconsistency in governance impacted on the quality and safety of the service provided but also meant that the provider did not achieve a satisfactory level of compliance with the regulations. The provider was issued with an urgent action on the day of the inspection, this will be discussed under Regulation 9, Residents' Rights.

The overall findings and regulatory actions identified, this inspection did not provide assurance that there was effective monitoring and oversight of this designated centre as follows:

The provider had not notified the chief inspector of a change to the floor plan of the designated centre, which pertains to Condition 1 of the designated centres current

registration.
The provider did not notify the chief inspector within the required time frame of alleged, suspected or confirmed abuse, that may have occurred within the centre.
The annual review contained no action plan for issues identified by the provider, for example, it was identified the policy on visitors to be reviewed and the health care actions plans for one of the houses to be reviewed.
The audit schedule was not sufficient to ensure oversight of the service and identify areas for improvement, such as, documented oversight was not present of audits completed by CNM1 and staff by the person in charge. Audits had not identified arising issues in the designated centres. For example an internal audit had not identified a broken window in the kitchen and damage to a kitchen unit in one of the bungalows.
The environmental restriction of two locked wardrobes in residents bedrooms and a locked press in the multi-sensory room was not identified as a restrictive practice and was not returned to HIQA in the written report the provided each quarter.

Judgment: Not compliant

Quality and safety

During the introduction meeting for this inspection it was indicated that the finances of some residents were managed by the provider and that others were managed by residents' families. It was highlighted though that for the residents whose finances were managed by the provider, their accounts were held centrally by the provider. In order to gain access to their money, a requisition form would have to be completed and sent to the provider centrally for approval. Once approved residents with staff support would have to drive to the provider's central location to obtain their money. Residents who had support from their families with their finances were supported by management and staff to request monies from the resident's family/representative when needed.

Concerns were identified on this inspection relating to resident's finances. The inspector's reviewed the minutes of safeguarding and regional management meetings held in 2023. In January 2023, a safeguarding meeting identified issues in relation to resident's access to their personal finances. From a review of financial records in place, it was evident that concerns were present. It was indicted that this situation had resulted in the person participating in management requesting money from the provider. The financial records available to review by the inspectors were only available from March 2023. Documentation reviewed during this inspection indicated that residents' capacity to manage their own financial affairs was assessed. The assessments reviewed during this inspection indicated that residents needed support from staff or management to manage their financial affairs. However, assessments did not identify any other issues which had been identified in the safeguarding meeting in January 2023. The nature of this information provided required further follow up and the provider was requested to review this matter with

their management team. This had not initially been regarded as safeguarding concern nor had they been notified to the Chief Inspector within three working days as required. Subsequently, the following day after the inspection, the provider notified the chief inspector of this concern.

This inspection also highlighted concerns in one bungalow of the centre regarding resident's access to a privacy. While an inspector spoke to a staff member it was indicated that part of the resident's bedroom door was to remain open in order to supervise. The provider had completed a review and identified no risk was present for residents to be supervised in this manner. It was subsequently indicated by the centres management that they were unaware of this practice taking place. The provider had also restricted uses of a technology devise, by replacing it for one with limited uses. On the day of the inspection staff informed an inspector of this information. Documentation reviewed on the day of the inspection provided conflicting information regarding consulting the resident on the changes. For example, minutes of a meeting held had consulted with the resident which resulted in the resident refusing the changes to the devise. While on the same date, another document provided consent signed by the resident. In addition, the provider had not identified the above practice as a restrictive practice or an infringement on the right to privacy for the resident. There was no evidence as to support the resident's right to gain access full to the devise and privacy in their living environment. This did not promote the rights of residents as per the regulations.

The inspectors reviewed a sample of residents' personal files. Each resident had an up-to-date assessment of their personal, social and health needs. Personal support plans were reviewed annually. Overall the plans in place were seen to reflect the health care needs and social needs, in meaningful activities for the resident's. A person centred planning process was followed to support residents to identify and achieve goals. Residents are supported by an activities co-ordinator for the centre to achieve goals and to support the activities in place each week. Examples of goals that had been identified for residents included a holiday away to a hotel of choice and a trip on the train to the zoo. Records were in place for regular meetings with residents, staff and activities co-ordinator to identify new activities and a record is maintained of how each resident enjoyed the activities they completed each week. Zumba, gardening and relaxation were also activities taking place in the centre.

Regulation 5: Individual assessment and personal plan

The personal plan was informed by the assessment of the resident's needs. The plan was the subject of review. The residents and their representatives had input into the support and care that was provided. Multi-disciplinary advice was sought and reflected in the plan. Appropriate goals were clearly identified in these plans and there was clear evidence of progression, completion and ongoing review of goals. Goals in place were meaningful and in line with residents' expressed wishes. For example, one resident had plans to go on the train to visit the zoo, while others

were planning a holiday.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had not ensured that each resident currently residing in the centre participated in and consented to decisions about his or her care and support. Also on the day of inspection, it was not evidenced that all residents had the freedom to exercise choice and control in his or her daily life.

This included in the areas of:

- Access to personal finances
- Access to personal possessions
- The use of restrictive practice to reduce access to personal possessions
- Control over personal and living space

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed.

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

Compliance Plan for Cork City North 18 OSV-0005628

Inspection ID: MON-0033288

Date of inspection: 12/04/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Statement of Purpose has been updated to reflect current staffing profile for the governance and management of the centre . Completed on 12/04/2023	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A schedule of audits will be reviewed by the PIC and set out in a timely manner over the year. The Pic will ensure full oversight of the audits. To be completed by 12/06/2023 • An application to vary was submitted to HIQA for approval. Submitted on 23/05/2023. • Restrictive practice has been reviewed to include all restrictive practice recorded and monitored as appropriate. Completed in April 2023 1st Quarter notifications. • All notifications since time of inspection have been notified in a timely manner. • The Policy on Visitors to People we Support is process of being updated. To be completed by 7.7.23	
Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• To ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights, the provider is currently creating a process for residents who have their personal money in a nominee account to be issued with a card in their own name for easier access to personal finances. To be completed by 15.01.2024.
• Residents will be supported through easy read documentation to consent to their own financial matters. To be completed by 15.01.2024
Restrictive practices will not be used to prevent residents having access to their own personal possessions.

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.	Substantially Compliant	Yellow	12/04/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	12/04/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	07/07/2023

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 09(2)(a)	The registered provider shall 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.	Not Compliant	Orange	15/01/2024
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.	Not Compliant	Orange	15/01/2024
Regulation 09(3)	The registered provider shall 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	Not Compliant	Orange	12/04/2023

	communications, relationships, intimate and personal care, professional consultations and personal information.			