## Centre name:

A designated centre for people with disabilities operated by Offaly Centre for Independent Living (Offaly CIL)

### Centre ID:

OSV-0001930

### Centre county:

Offaly

### Type of centre:

Health Act 2004 Section 39 Assistance

### Registered provider:

Offaly Centre for Independent Living (Offaly CIL)

### Provider Nominee:

Michael Nestor

### Lead inspector:

Louise Renwick

### Support inspector(s):

Conor Brady;

### Type of inspection

Unannounced

### Number of residents on the date of inspection:

5

### 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 un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>09 September 2014 10:00</td>
<td>09 September 2014 17:00</td>
</tr>
</tbody>
</table>

The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
</tr>
<tr>
<td>Outcome 05: Social Care Needs</td>
</tr>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 09: Notification of Incidents</td>
</tr>
<tr>
<td>Outcome 11: Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 12: Medication Management</td>
</tr>
<tr>
<td>Outcome 13: Statement of Purpose</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 15: Absence of the person in charge</td>
</tr>
<tr>
<td>Outcome 16: Use of Resources</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
</tr>
<tr>
<td>Outcome 18: Records and documentation</td>
</tr>
</tbody>
</table>

**Summary of findings from this inspection**

This inspection was to follow up on the actions generated from the inspection of 13 May 2014, where 15 outcomes were found to be non-compliant with the Care and Support of residents (children and adults) in designated centres for disabilities Regulations 2013.

At this follow up inspection, the inspectors met with the nominated person in charge, staff members, residents, the provider nominee and the chairperson of the board over the course of the day. Inspectors reviewed documentation such as assessments, policies and procedures, daily notes and spoke with both staff and residents.

While inspectors found evidence of some improvement since the previous inspection, inspectors were not satisfied that the provider had demonstrated suitable progress overall, to ensure ongoing compliance with the Regulations and Standards.
Inspectors found non-compliances across the same 15 outcomes.

Some new practices were evident on this inspection, for example, some policies and procedures were now accessible to staff in the centre, the interior building had been painted, the introduction of new recording sheets, draft policies in relation to some clinical areas, and the presence of a manager on site full time in the centre had resulted in some of the positive changes noted in this report. However, little or no changes to the oversight of the safety and quality of the service, resulted in non-compliances remaining across most outcomes.

Inspectors found that the provider’s response to the action plan, which outlined the steps that it would take to become compliant, had not been carried out as described or within the specified time frame.

Inspectors were informed that the provider nominee would not be available to the inspectors past a particular time, and that information required to be reviewed in the head office was not available to inspectors on the day of inspection. The inspectors met with the provider nominee along with the chairperson of the board to give brief and preliminary feedback on concerns that were still evident. Following on from this the provider was invited to attend the Authority’s offices in Smithfield for formal feedback, and to discuss the Authority’s ongoing concerns regarding the governance and management of the designated centre.

Following on from this inspection, the provider informed the Authority that admissions for respite services would cease temporarily, until such a time when a suitable person in charge could be been appointed. As of the 23rd of March 2015 the provider has put forward a person to act as provider nominee along with the role of person in charge for this centre. An updated action plan was submitted to the Authority by the newly appointed person in charge which offered some assurances to the Chief Inspector that there was a plan to address the non-compliances found.
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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
While some improvements were noted in relation to this outcome, inspectors found there was non-compliance overall. Some actions had been satisfactorily addressed, some were still in need of address, and new actions were also identified.

Evidence of some positive changes noted:

- Resident meetings at the beginning of each respite stay were held and documented, and residents' opinions were sought on how they would like to spend their respite break.
- Use of the suggestion box and resident satisfaction questionnaires.
- Consultation was held and documented with residents regarding the painting of the building.
- Suitable user friendly locks had been installed on bathroom doors to promote privacy.
- The use of blinds over notice board that displayed information was now in place.
- The door to an adjoining office was now closed to promote the privacy of residents.

Inspectors found that the management of complaints was still in need of improvement in order to be compliant with the Regulations. Since the previous inspection, a copy of the organisational complaints policy was now on site and accessible to staff but there was nothing on display to show residents who they should make a complaint to. While this policy was now available for inspectors to review, the practices in relation to this policy were not always fully adhered to. For example, the policy described the person who handles a complaint as a complaints officer, however, it was not clear who the nominated person to deal with all complaints for the designated centre was. Inspectors
found evidence of complaints raised by residents through consultation meetings that had not been recorded in the complaints log, and there was no evidence to show that this complaint had been responded to or acted upon. Inspectors also found that the policy did not sufficiently allow for adequate ongoing review to ensure that all complaints were responded to, as required by the Regulations.

Inspectors found that the provider had not implemented actions as outlined in the action plan from the previous inspection. For example, policies in relation to privacy and dignity, personal and intimate care, and residents leaving the unit had not been drawn up as stated in the action plan response. Inspectors also found that the provider response in relation to transport had not happened. This is actioned under Outcome 18.

In addition the provider stated on the action plan response that ‘funding was sought and made available to OCIL to purchase a wheelchair accessible transport which is now available to Leaders 7 days a week”’. The nominated person in charge explained that transport had not been made available as most staff working in the centre could not drive. There remained the transport provided by the HSE for residents on Wednesday for social outings, this had not changed since the previous inspection.

Overall inspectors found that further improvements were required in relation to this outcome, and the providers response to the action plan had not been fully implemented.

Judgment:
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 04: Admissions and Contract for the Provision of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.</td>
</tr>
</tbody>
</table>

| Theme: |
| Effective Services |

| Outstanding requirement(s) from previous inspection(s): |
| Some action(s) required from the previous inspection were not satisfactorily implemented. |

| Findings: |
| Inspectors found that while some improvements had been made in relation to admissions and contracts for the provision of services, they were not enough to meet the requirements of the regulations. |

A draft admissions policy had been drawn up which outlined the specific criteria for admission. There was also a new template for "leader contracts" to explain the nightly cost and the terms and conditions that residents must adhere to during their stay.
Inspectors were concerned that on the day of the inspection that a resident had been admitted as an emergency admission through the HSE, and required particular health care support. The nominated person in charge explained that this admission was outside of what was described in the criteria in the admissions policy. This resident required bed rest/ convalescent care, which was specified as not being catered for in the admissions policy. Additional support from the HSE had been required from the community nursing team to ensure this residents needs could be catered for while in the designated centre.

On review of the documentation for the five current residents, inspectors found that only two had signed written "leader contracts" in place. The contracts did not clearly outline what was on offer in the designated centre, and did not cover any additional costs that may be incurred during a respite stay. For example, the cost of a taxi on days when no transport was available. The statement of purpose had not been amended to include the details of the admission criteria as stated in the provider’s action plan response.

Judgment:
Non Compliant - Major

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors were not satisfied that residents' social care needs were being fully met in the designated centre.

The draft admissions policy described the centre as providing individuals with a "holiday/break/ recess/ vacation/ reprieve from their normal daily living environment."

This was not evident on inspection. As mentioned in outcome 1, transport remained available for outings on only one day in the week. For residents who could travel independently there was the option to leave the centre as they wished to visit the town. However, for residents dependent on more support this was not always possible due to
staffing and the mix of residents. There was no evidence of in-house courses on offer as the draft admissions policy detailed. Minutes of a residents meeting in July indicated that residents were seeking increased staffing for social activities.

Inspectors did note residents enjoying the garden space in the front of the building and chatting with staff throughout the day. Residents explained that they had been part of a meeting and decided to use the weekly transport to go on a trip to Salthill the following day.

Although there were some changes to the assessment documentation that was used at each admission, these did not always result in a clearly documented plan for the residents' stay. Inspectors noted involvement of the personal assistants with an assessment tool for daily living now available, which was an improvement since the last inspection. However, these had not been completed consistently for residents and did not result in plans to ensure positive social activation during their stay.

Assessments did not fully capture residents' health, personal and social care needs. One resident had been identified at admission as requiring a seating assessment while in the centre. On discussion with the nominated person in charge, this had not been carried out. A resident who had three slips/trips/falls during the course of a stay did not have a re-assessment carried out or a clear plan in place to reduce the risk of this happening again. Although some improvements had been made in regard to assessments, they did not result in documented plans to guide the supports on offer during the residents stay, and ensure all identified needs were being met.

**Judgment:**
Non Compliant - Major

---

### Outcome 06: Safe and suitable premises

*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors found that the designated centre had been recently painted internally, and on the day of inspection it was bright and clean. The walkway leading to the entrance of the centre had been cleared of all clutter, leaves and weeds, and inspectors noted the pathway had been repaired to ensure easier access for residents using a wheelchair. On
arrival to the centre a resident was enjoying the garden space.

The internal walls and doors had been painted in contrasting colours to assist residents who presented with visual impairments. The nominated person in charge had sought the opinion of someone with a visual impairment to ensure the colours promoted access. However, during the course of inspection, some residents said that the current colour scheme did not assist them with their vision, and was causing them some difficulties in locating the bathroom area easily. Inspectors were not satisfied that the centre was fully suitable to meet the needs of residents at present, and to offer a service in line with the ethos of the organisation. For example, door access in the building and bedrooms did not promote independence and full accessibility as identified at the last inspection. Further assessment and review of the accessibility of the building is required to ensure the building meets the needs of residents. This is also actioned under Outcome 5.

The nominated person in charge informed inspectors that after consultation with residents, certain furnishings had been requested and ordered. For example different duvet covers, and curtains for window. Some of the tools to assist residents with their mobility had been reassessed and improved. For example, the addition of black markings to grab rails to assist residents who had visual impairments to locate them easily.

Areas still in need of improving and address:

- suitable storage for equipment. This was proposed in the action plan to be completed by July but was not in place on inspection.
- push bar exit door from communal room was proposed in the action plan to be completed by August, but has yet to be completed.
- Contracts and records of regular servicing of equipment such as hoists and beds had not been carried out.
Inspectors did note a quote for a full service of all equipment had been sought, but to date had not been carried out.

Judgment:
Non Compliant - Moderate

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors were not satisfied that appropriate steps had been taken to ensure residents’ safety. The provider had not addressed the actions from the previous inspection. Inspectors were concerned that there was a lack of understanding from the provider in relation to risk, which resulted in limited systems in place to promote the health and safety of residents and staff in the centre.

There was no risk management policy or procedure to guide practice. The provider had stated in the action plan for the previous inspection that this would be addressed in August 2014. Inspectors were concerned that in the absence of a risk management policy and procedure to guide practice, risks were not being adequately identified, managed or reviewed.

Some improvements were noted since the previous inspection in relation to infection control. The nominated person in charge informed the inspectors that staff had received training in infection control from the infection control team in the adjoining hospital. Staff now had access to the HSE infection control policies which had been borrowed from the hospital team. Practices in relation to the waste storage room in the adjoining hospital had improved, with a sign in and out sheet now in place to show who was last in the waste area. This allowed for ownership of any issues should they arise in relation to infection control practices.

Inspectors reviewed the log of accidents, incidents and near misses. There was no evidence of a system to learn from incidents to prevent them from occurring again. For example, one resident had three incidents of slips, trips or falls during the week of a respite stay. There was no evidence that any learning had been gained from the first incident to avoid or reduce the risk of a reoccurrence. The absence of a risk management policy resulted in no guidance for staff in this regard.

The health and safety statement was in draft format, and was currently being amended to be centre specific.

Documentation in relation to the testing of the fire alarm was now accessible to inspectors, with maintenance staff from the adjoining hospital providing inspectors with the required information. Certain equipment had been purchased to assist in evacuation such as ski-sheets for all beds. Some files contained personal evacuation plans for residents to describe the support they required in the event of an evacuation. These were improvements since the last inspection.

Evidence was not available in relation to the emergency lighting system. While training and a safety assessment had taken place since the last inspection, the inspectors were concerned that no fire drills or simulated evacuations had taken place. The evacuation plan showing the nearest exits had not yet been put on display.

Although the nominated person in charge could outline where emergency accommodation could be found in the event of an emergency, there was no documented plan for this to guide staff. A "policy to be designed for emergency care and training provided" had not been completed as outlined in the provider’s response to the action plan.
New individual risk assessments were introduced since the previous inspection, however these were not consistently completed for all risks, and did not clearly show what measures would be put in place to reduce or remove the risk identified. For example, a risk assessment was completed due to concerns from a staff member that a resident had started smoking again and her ability to do so safely had deteriorated. There was nothing to indicate what had changed to ensure this new risk was appropriately managed for the resident.

Overall, inspectors remained concerned that there was a lack of oversight and review arrangements in place to ensure all risks were clearly being identified, assessed and managed within the designated centre. There was no evidence that training in risk had been provided to the nominated person in charge or staff as outlined in the providers action plan response.

**Judgment:**
Non Compliant - Major

---

**Outcome 08: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
In the absence of robust policies to guide practices, inspectors were not satisfied that residents were being safeguarded at all times. For example, the lack of policies on risk management, residents going missing, and intimate care, resulted in a lack of guidance for staff, and did not ensure a proactive approach to safeguarding of residents while in the centre.

A fire evacuation or drill had not taken place since the previous inspection to ensure staff could effectively put their training into practice in the event of a fire. Not all staff files were available for inspectors’ review to offer assurances that all staff had been appropriately Garda Vetted. Of the staff files that were reviewed, only one file had the required references. This did not offer assurances to inspectors that recruitment practices were robust to safeguard residents.
Intimate care plans had not been put in place since the previous inspection to guide staff in supporting individuals. A policy to govern personal care, as outlined in the provider response was not evident on inspection.

Consent had been obtained by residents for the use of bedrails on a new consent form which was an improvement since the previous inspection, and there was a policy drafted on restrictive procedures which was found to be detailed and satisfactory.

**Judgment:**
Non Compliant - Major

---

**Outcome 09: Notification of Incidents**
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspectors.

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors were not satisfied that a clear record was maintained of all incidents occurring in the designated centre, and where required notified to the Chief Inspector within the set time frame. Prior to this follow up inspection, no notifications had been received. On review of documentation during this inspection, the nominated person in charge was advised by inspectors of an incident that was a notifiable event and requested written submission. An NF05 notification was submitted a number of days following the inspection.

No quarterly or nil return notifications had been received prior to this inspection. The provider had stated in its action plan response that the required quarterly notification would be submitted as required. Inspectors were not satisfied that the provider nominee or the nominated person in charge were fully knowledgeable on their responsibilities under this outcome.

**Judgment:**
Non Compliant - Major
| **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):**  
Some action(s) required from the previous inspection were not satisfactorily implemented. |
| **Findings:**  
Inspectors were not satisfied that the actions had been fully addressed under this outcome.  
Inspectors found that there were good relationships between the centre and the community care team. For example, access to tissue viability nursing, public health nurse and pharmacy support for the staff team to call upon. Inspectors found that due to the deficiencies in documentation as previously outlined, not all identified needs were being planned for or met by staff. Where assessments had been carried out, plans were not always evident or guided practice. For example a resident assessed as a risk of developing a pressure sore did not have a plan to outline how this would be prevented or managed while staying in the centre.  
Inspectors noted that staff had received training in epilepsy since the last inspection, and the use of a new epilepsy care plan was in place, however, further improvements were still required across other health care areas.  
Residents were also concerned that staff did not have the required knowledge or guidance to care for the complex needs of a resident. On the day of inspection a resident had a pressure sore with a sophisticated mechanical vacuum in place. A draft pressure care policy had been written up to offer guidance to staff since the last inspection, however, it did not include guidance on the use of this type of machine or dressing, and no training had taken place for staff on wound management. The community nursing team were offering support to the centre to allow this resident to obtain emergency admission, and had written up a wound care plan. The nominated person in charge was not aware of the grade of pressure sore, but understood that the wound was improving since the start of the resident's stay. Verbal advice in relation to the resident was not clearly documented to ensure a consistent approach from all staff.  
Inspectors were not satisfied that a strong system was in place to ensure that all residents' assessed needs were being planned, met and monitored while in the designated centre. |
| **Judgment:**  
Non Compliant - Major |
### 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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Since the previous inspection, a medication management policy and procedures was on site and available for staff to access. This was an improvement on the last inspection, where nurses felt there was a lack of policies to guide their practice. While inspectors noted this improvement, the process of assessing residents abilities to self medication were not comprehensive enough, as identified at the previous inspection. There had been no changes made to the assessment template, as outlined in the provider's response to the action plan. Inspectors found that the assessments required improving to ensure adequate assessment of risk and ability were considered.

Checks were now carried out at routine times in the day to ensure residents who managed their own medication were storing them safely in the lockers provided.

There was no evidence of training provided to staff nurses in medication management, or audits or reviews carried out on medication management in the designated centre.

**Judgment:**

Non Compliant - Moderate

---

### Outcome 13: Statement of Purpose

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Inspectors were not satisfied with the progress made under this outcome. Since the
previous inspection, there was now a written statement of purpose in the designated centre. The centre was given feedback on two versions of the statement of purpose that had been submitted prior to this inspection, and informed that they did not include the requirements of Schedule 1.

The statement of purpose reviewed on this inspection still did not meet the requirements of the Regulations. Inspectors were not fully satisfied that the services as described in the draft statement of purpose were not clear reflection of what was on offer in the centre. For example the use of a wheelchair bus two days each week.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 14: Governance and Management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>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.</em></td>
</tr>
</tbody>
</table>

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors were not satisfied that there was robust governance and management in place to ensure that the service provided is safe, appropriate to meet residents' needs, consistent and effectively monitored.

Inspectors were notified prior to the inspection of a change of person in charge. This person was full time in the centre and staff reported that they felt better supported. However, on review of the documentation submitted with the notification, inspectors found that this person did not have the necessary qualifications, skills or experience to management the designated centre. The provider was informed of this by letter date 2 September 2014.

Inspectors were not satisfied that there was a clear management structure in place which outlined the roles and responsibilities of all persons involved in the running of the designated centre. For example, neither the provider nominee or the nominated person in charge had access to staff files of staff who worked night duty in the centre, as they were managed by another supervisor. Inspectors were informed that there was a person involved in writing up the Schedule 5 policies and procedures for the designated centre,
however the nominated person in charge was not aware of this person's role in the organisation. From a regulatory perspective, some of the responsibilities of the nominated person in charge were being managed by the provider nominee, i.e Staff files.

There was no evidence of performance management or appraisals being carried out which was not in line with the organisational policy, which said this would be completed on a yearly basis with staff. There was no evidence in staff files of access to continuous professional development for staff nurses. The nominated person in charge explained that draft template supervision forms where being worked on currently, and at present informal supervision was taking place on a daily basis with any staff that required it.

Information required to be obtained in respect of the nominated person in charge was not fully in place. for example, proof of person's identity, documentary evidence of qualifications and two written references were all found to be absent from the staff file.

As evidenced across the non-compliances in other outcomes, inspectors identified a lack of monitoring systems in place to ensure the effective delivery of care to residents. Clear lines of reporting were absent to ensure accountability. There was no evidence that any unannounced inspections had been carried out by the provider or nominated person to review the safety and quality of care. As evidenced in outcome 7 there was a lack of oversight, and unclear lines of escalation in the event of serious incidents or risk.

Inspectors were not satisfied that the provider, the person nominated to act on behalf of the provider and the nominated person in charge were fully aware of their obligations within the Act and Regulations, as evidenced from the non-compliances across all outcomes.

Inspectors were not satisfied that the provider, the person nominated to act on behalf of the provider and the nominated person in charge were fully aware of their obligations within the Act and Regulations, as evidenced from the non-compliances across all outcomes.

**Judgment:**
Non Compliant - Major

---

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

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

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors were not satisfied that there were clear arrangements in place for times when the nominated person in charge was absent from post. The action plan response outlined that the provider nominee would act as person in charge in the event of an absence. Inspectors were not satisfied that this was a suitable arrangement due to concerns as outlined under outcome 14 governance and management.

For short term absences when the nominated person in charge was not present, one of the nurses acted in a senior role. However, this was not outlined in the roster, and inspectors were not satisfied with the on call arrangements should something happen at times when there were no nurses on duty. There was a lack of support arrangements in place should staff working nights need guidance or support.

**Judgment:**
Non Compliant - Moderate

---

**Outcome 16: Use of Resources**
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

**Theme:**
Use of Resources

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors were not satisfied that this outcome was satisfactorily met.

Due to limited information available, inspectors found that there was again a lack of transparency in relation to the resourcing of the designated centre, and who was responsible for the provision of resources. The nominated person in charge had no access to or control over the budget allocated for the centre, this responsibility rested with the provider nominee. An arrangement was in place that the hospital remained responsible for the maintenance of the fire detection and alarm system, but would make documentation available to the centre for the purpose of inspection and assurances. This was an improvement since the previous inspection.

There was a lack of clarity around the staffing resources for the designated centre. There was an absence of contracts in place for staff to determine the hours to be worked. The planned staff roster was available to inspectors, but did not clearly outline
the hours that nurses would work and the actual hours worked was not accessible for comparison. Some staff who worked nights were employed as personal assistants through a scheme operated by the Department of Social Protection, but information in the staff files for these staff were not available to the nominated person in charge.

The action plan response outlined that funding for new transport, and a wheelchair accessible vehicle was now available 7 days a week to residents of this centre, however this was not found to be available on inspection.

Inspectors found that the designated centre's routines and activities were still resource led to a certain extent. For example the provision of hospital meals at a set time for residents, and the use of a bus for outings on a set day during the week.

Overall, inspectors were not appropriately assured that the designated centre was sufficiently resourced to meet the needs of residents and to deliver the services of "promoting and empowering independence" as outlined in the draft statement of purpose.

**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors were not satisfied with the progress made under this outcome.

The responses as outlined in the provider’s action plan had not been implemented. For example the response read "a person has been nominated to complete a review of staff training and determine and prioritise the training needs of staff. A schedule for the year of training will then be drafted." There was no evidence of this on inspection.

Complete training records for all staff were not made available to the inspectors during the course of the inspection. There was limited information on site to evidence that training had taken place. There was no schedule of training available to show inspectors
how the training needs were being met. Some evidence was available to show inspectors that there had been training by an external trainer in epilepsy for the staff team which was an improvement since the last inspection. There had been a recent emergency admission of a resident with a grade 3 pressure sore, however, there had been no training in wound management for staff since the previous inspection. This did offer assurances that training needs were being prioritised to meet the most pressing needs of residents.

The failings as identified under outcome 14 in relation to the governance and management, resulted in insufficient supervision being in place in the centre to ensure the management of the full staff team.

Information as required in relation to staff employed in the centre was incomplete and did not meet the requirements of the Regulations. Inspectors were not satisfied that all staff were recruited, selected and vetted in accordance with best recruitment practices, or the organisation's own recruitment policies. This will be further discussed under outcome 18 documentation and records.

Inspectors found that staff now had access to the Regulations and Standards on site for staff which was an improvement since the previous inspection.

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors saw evidence of some improvements in relation to documentation available in the designated centre since the previous inspection, but further improvements are required.
Documentation in relation to Schedule 4 of the Regulations had been improved upon, for example with records of fire system maintenance, and complaints log now available to the inspectors. There was also now a copy of the draft statement of purpose. Some improvements were still needed. For example, a record of attendance of staff training, a record of whether the roster was actually worked.

There was now a selection of policies and draft policies available to staff in the designated centre. For example, the complaints policy, the medication management policy and the draft admissions policy. However, not all Schedule 5 policies had been written up and fully implemented as required by the Regulations.

Information required under Schedule 2 to be held in respect of any staff employed in the designated centre were not fully in place. On the day of inspection only six staff files were available for inspectors to review. Of the staff files available there were gaps identified in the documentation required. For example, proof of identity, evidence of qualifications, the required written references, and contracts to outline the start date of employment, the position held and the hours to be worked. When inspectors requested the staff records for two nurses the provider nominee informed inspectors that there were no files for these staff.

While some improvements were noted as mentioned above, a more robust system of documentation and record keeping is required to ensure effective oversight of all aspects of service delivery.

**Judgment:**
Non Compliant - Moderate

---

**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:**

Louise Renwick
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Offaly Centre for Independent Living (Offaly CIL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001930</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>09 September 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>01 May 2015</td>
</tr>
</tbody>
</table>

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:
The provider had not implemented the actions as stated in the previous inspection report action plan resulting in no improvement to the provision of opportunities for residents to participate in activities in accordance with interests, capacities and needs.

Action Required:

---

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

Rights
- Each service user is made aware of their Human Rights on their first admission to centre and a copy the human rites charter will on public display in the unit.
- A copy of the United Nations Conventions on the Rights of Persons with disabilities is available in the CNM2 Office for each service user to study and have explained to them in a format which they understand
- The rights of the service user in relation to residential care is noted in the Agreement for centre Users& Release of information Form and will be explained in jargon-free language that is understood by the leader on admission to the unit.

Dignity
- Service users have access to jargon-free information about services when they want or need it by asking any member of staff.
- Local advocacy service information is given to all service users on admission-
- All individuals resident in centre are treated with respect and autonomy and will be given a key to exit and enter the unit at their own discretion with reasonable risk considerations and as per admission/discharge policy guidelines
- All residents have bedroom which can be locked to maintain privacy as with their bathroom facility. A personalized ‘Do not disturb’ sign which can be written on by the leader to add extra details (e.g.- do not disturb until 10.15am or ‘prayer in progress’, do not disturb until after 6.15pm or family member visiting- do not enter)

Consultation
- Peer group called ‘Laois Offaly Leader forum’ were asked to act as advocates for potential service users of the service. The forum meets twice a month and consists of OCIL service users with both physical and sensory disabilities.
  Their agreed role is to act as guidance for Management in the formation of policies pertaining to the day to running of the service from the prospective of the service user. The aim to present ideas and suggestions as identified by potential service users themselves as to the needs and ambitions of the leaders resident in centre. Minutes of LF meeting to be retained by CNM2.
- The Offaly Leader is a monthly newsletter that reaches all service users of OCIL and the employed Personal Assistants of the organisation. Opportunities for feedback through the newsletter gives the service users and PAs alike, an opportunity to give feedback through our Public Relation Officer either anonymously or named as desired. Records to be maintained by CNM2.
- All service users on admission to the unit will be consulted on their support requirements, their goals and ambition for their stay in the unit and also on their needs on discharge home. This will be dealt with by the Clinical Nurse Manager and signed off on discharge form the unit.
- Service users are fully involved in any decision that affects their care, including personal decisions, such as what to eat, what to wear and what time to go to bed, and wider decisions about the service such as menu planning or recruiting new staff and policy formation.
- The service users will have the option to attend a group discussion pre-discharge to
collectively add their views and opinions regarding the running of the unit and to discuss the good and bad points of their stay for the purposes of on-going development of the unit. CNM2 hold the responsibility to review the minutes and empower leaders to make the changes they aim for.

- PDSA Cycles will be used for all systems of Consultations with Monthly review by CNM2 and PIC.

- Folder has been created listing recreational activities and social outings available to residents that take into account various interests, capacities and developmental needs. Local Sports inclusion Officer is developing a specific Sports programme for service users to include: Boccia, Target Throw, Indoor Kurling, Go For Life Games (Lobbers, Flisk, Skidilis) • Wheelchair Basketball, Adapted version of goalball for visual impairment (using rattle balls) Table tennis in room where pool table currently is

2015

Relevant Documentation Attached:
Scheduled 5,

| Proposed Timescale: 01/05/2015 |
| Theme: Individualised Supports and Care |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all complaints identified were documented to show the outcome, any actions taken, and if residents were satisfied with the outcome.

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

Please state the actions you have taken or are planning to take:
- Complaints Policy, procedure and protocols have been developed
- The PIC will now document the outcome of each complaint and all/any actions taken.
- A framed process of complaints will now be displayed in a prominent location where all service users access
- How to appeal a decision has clearly been defined in the newly created leader contracts.
- Training for all new Staff members booked for 05.06.15

| Proposed Timescale: 01/05/2015 |
| Theme: Individualised Supports and Care |

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
It was not clear who the nominated person to deal with all complaints for the designated centre was.

Action Required:
Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

Please state the actions you have taken or are planning to take:
Disability advocate in Offaly area has been identified as external individual to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints is maintained.

Proposed Timescale: 01/05/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no one identified to review that all complaints had been appropriately responded to.

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

Please state the actions you have taken or are planning to take:
• The PIC was nominated as the complaints officer No. 1 for centre and CNM2 will be complaints officer no.2
• In the event that the PIC is involved in the matters as the subject of a complaint, the CNM2 will deal with the complaint
• Lines of responsibility in relation to complaints will be included in leader contracts.
• Leader will be informed of Advocates numbers for contact of reference and support on admission

Proposed Timescale: 01/05/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was nothing on display to show residents who they can raise a complaint to, or outline the complaints policy.
Action Required:
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
• The resident’s contracts clearly outline how to make a complaint and will explained to them on each admission to the unit.
• A copy of the complaints procedure will be made available to all residents with information on how to access it being displayed in a prominent position in a framed statement. This document states who the complaints officers are and other options on who to approach for advice and support in this area.

Proposed Timescale: 01/05/2015

Outcome 04: Admissions and Contract for the Provision of Services
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not admitted in line with the described criteria in the admissions policy.

Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
• Statement of Purpose governs the admissions policy and includes a risk assessment being carried out by CNM2 pre-admission
• A list of potential service users will be complied from the previous resident listing and the present list of OCIL Community PA service users will be made.
• An interview date for pre- respite assessment will be carried out with CNM2/PIC to identify suitable residents who may be booked in for the reopening of the unit and the 3 weeks that follow
• How people apply for a service is detailed in the policy with a referral pathway identified within the policy. Clear outline of exclusion criteria for admission is included also.
Statement of purpose (draft only at present, final document will depend upon negotiations with the HSE)
Centre information brochure to be developed

Proposed Timescale: 12/06/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in
only two contracts were in place for residents admitted during this stay.

Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
• The PIC will ensure that all service users have a signed contract of service on file
• Terms and conditions are clearly outlined in the Leader Contracts which are explained to each service user pre-admission and again on the day of admission to the unit.

**Proposed Timescale:** 01/05/2015

### 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:**
A seating assessment for a resident had not be carried out as required on the pre-admission assessment

**Action Required:**
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
• Comprehensive assessments are completed prior to admission and reviewed on day of admission and on an ongoing basis by Clinical Nurse Manager 2 which includes ALL activities of Daily living with relevant referral systems in place.
• Daily journals will be completed by the Leader assisted by the PAs where necessary and reviewed by PIC
• Weekly Leader journals will be reviewed pre discharge from unit on the Friday

**Proposed Timescale:** 12/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no system in place to ensure all residents assessed needs were planned out and met.
**Action Required:**
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
- Person Centred planning training for all staff will take place on June 4th 2015
- Person Centred planning training for service users will take place either as group or a one to one basis on the Monday of all first admissions
- A review will be carried out by CNM2, pre discharge of goals identified and outcomes met.
- Relevant referrals will be made by CNM2 to ensure continued care approach is maintained.
- Liaisons with MDT will be carried out pre-discharge of service user from unit and full explanation given both verbally and written to the service user with a record made in their PCP

**Proposed Timescale:** 01/05/2015
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The absence of personal plans based on pre-admission assessment did not ensure that the designated centre was suitable for the needs of each resident prior to admission. Limitations to the environment did not ensure that the centre was suitable to meeting the needs of all residents.

**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:**
- CNM2 to arrange pre-admission assessments which may take the form of telephone triage, pre admission meeting, house call visit, contact with PHNr and/or GP opinion
- Pre-admission form may be completed by either CNM2, the individual service user with/without assistance of GP/PHNr or a combination of all of the above depending on the individual case profile
- The PCP will be reviewed daily and up to date documentation will be carried out by all staff on duty and by the leader themselves in the daily notes and the weekly Leader Journal

**Proposed Timescale:** 01/05/2015
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement**
**Personal plans were not in place for all residents to guide their care based on an assessment of need.**

**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:**
- An assessment of need is completed prior to admission and personal plans are therefore created and interventions delegated among all members of the team and to the leaders themselves.
- This will be reviewed on admission to the centre, updated daily and signed off on discharge from the unit.

**Proposed Timescale:** 01/05/2015

**Theme:** Effective Services

---

**Personal plans were not reviewed when residents' needs changed.**

**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:**
- CNM2 will complete a pre-admission assessment on all potential service users prior to their arrival to the unit
- PA and the leader will participate in the review of the plans on a daily basis and make relevant changes, additions and make relevant notes pertaining to the activities of daily living of the service users
- Plans are now devised in an attempt to ensure that the centre, the staff and the activities are suitable to meet the needs of all residents prior to admission.

**Proposed Timescale:** 01/05/2015

---

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The premises do not fully promote accessibility.
**Action Required:**
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

**Please state the actions you have taken or are planning to take:**
- Old/outdated furniture has been removed, promoting maximum accessibility
- A ramp has been built for the entrance, along with resurfacing of tarmac.
- Repainting of unit with colours to assist visually impaired leaders has been carried out
- The leader forum have been invited to carry out an audit as a peer group of potential service users and their report is awaited (Date to be confirmed)

Relevant issues to be completed:
Purchase of visual and accessible aids, I have consulted with NCBI in this regard. Also training for PA’s regarding assisting visually impaired service users to be completed on 18th June.

**Proposed Timescale:** 18/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that equipment was maintained in good working order and regularly serviced.

**Action Required:**
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

**Please state the actions you have taken or are planning to take:**
- Hoist was serviced on the 15/10/14
- All other equipment was serviced on the 15/10/14
- Maintenance will be carried out by adjoining hospital for future maintenance needs.

**Proposed Timescale:** 01/05/2015

**Outcome 07: Health and Safety and Risk Management**
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no policy for risk management to guide practice
**Action Required:**
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
- A risk management policy is now complete
- Risk management training will be carried out on 17.06.15
- Each service user will be individually assessed on their PCP and risk assessed on their daily journal and assessed pre discharged from the unit
- Current fire safety statement to be reviewed
- Fire safety training and evacuation drill confirmed for 23rd June

**Proposed Timescale:** 23/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were insufficient measures in place to control all risks.

**Action Required:**
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**
- Risk management and Incident management carried out on 06.11.14 on each area of the centre.
- Clochan House Risk Registered commenced and ongoing live document
- Training booked for 17.06.15

**Proposed Timescale:** 01/05/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no formal system of review of learning from adverse incidents, events or near misses.

**Action Required:**
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
• A policy has been drawn up in relation to accidents & incidents, Errors and Near Misses
• The PIC will review accidents and incidents in supervision sessions and also at monthly group staff meetings.
• Training for all staff for 17th June 2015

Accident and incident record documentation to be developed

**Proposed Timescale:** 23/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no formal plan in place for responding to emergencies to guide staff.

**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:**
To make arrangements with adjoining hospital & local hotel that will enable centre to respond to emergencies.
Emergency accommodation policy to be developed

**Proposed Timescale:** 29/05/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
No fire drills or mock evacuations had taken place since the last inspection

**Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
• A practice fire drill will take place with new staff members prior to the admission of service users in 06/15 (Booked with HSE awaiting dates)
• Fire register will then be updated
• Safety statement completed to include actions and procedures regarding fire drills/mock evacuations
• Centre to be included in fire drills which take place through the adjoining hospital.

Current fire safety statement to be reviewed
<table>
<thead>
<tr>
<th>Proposed Timescale: 23/06/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
</tbody>
</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The evacuation plan showing the fire exits was not on display

**Action Required:**
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

**Please state the actions you have taken or are planning to take:**
- Now in place in each room

---

<table>
<thead>
<tr>
<th>Proposed Timescale: 01/05/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Evidence of quarterly testing of the emergency lighting system and fire doors was not available

**Action Required:**
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

**Please state the actions you have taken or are planning to take:**
Task has been completed but not documented evidence can be obtained, task will be repeated June 23rd

---

<table>
<thead>
<tr>
<th>Proposed Timescale: 23/06/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 08: Safeguarding and Safety</strong></td>
</tr>
<tr>
<td><strong>Theme:</strong> Safe Services</td>
</tr>
</tbody>
</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no personal plans to guide staff on how to support residents with intimate or personal care.

**Action Required:**
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
• Policy completed on intimate care in consultation with nursing staff, board of directors to approve.
• Prior to admission residents are asked about their preference in relation to personal and intimate care and if they have preference in male/female staff assisting with their needs in this area.

Proposed Timescale: 01/05/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No written notifications had been received to the Authority to date regarding the use of bedrails.

Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
• An assessment of risk is now completed prior to the use of bed rails.
• All Notifications under Regulation 31 will be adhered to on reopening of centre 2015
• PIC responsible for all notification to Chief Inspector

Proposed Timescale: 01/05/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
On inspection records indicated that a resident had left the building without staff knowledge. This had not been notified to the Authority.

Action Required:
Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.
Please state the actions you have taken or are planning to take:
• Due to the philosophy of independent living a section is included in resident’s contracts regarding signing in & out of centre and importance of staff awareness.

• Notice will be sent within 3 working days of future unexplained absence of a residents should the occurrence take place.

Proposed Timescale: 23/06/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of sufficient personal plans to address identified needs.

Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident’s personal plan.

Please state the actions you have taken or are planning to take:
• PCP’s for new leaders are carried out prior to admission, on admission and updated during the leaders stay in the centre. Pre admission assessment now includes an MDT approach for example, PHN, GP, OT and chiropody.
• New documentation folders are now in place in the centre which clearly identifies all health care needs for leaders having regard to their personal plan.
• Linkage with PC teams encouraged and ongoing by staff (GP, PHN, OT & Pharmacy) & records kept of same.

Daily journal to developed

Proposed Timescale: 30/06/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There had been no change to the previous assessments, which were not sufficiently comprehensive.

Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age
and the nature of their disability.

**Please state the actions you have taken or are planning to take:**
- PCP has been updated to include service choice in all areas
- Medication management policy in place
- Training for new staff members booked for 03.06.15

**Proposed Timescale:** 03/06/2015

---

### Outcome 13: Statement of Purpose

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The statement of purpose did not meet the requirements of Schedule 1

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

**Please state the actions you have taken or are planning to take:**
Statement of purpose, draft only at present, final document will depend upon negotiations with the HSE

**Proposed Timescale:** 12/05/2015

---

### Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The person put in place by the provider as person in charge did not meet the requirements of the regulations.

**Action Required:**
Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

**Please state the actions you have taken or are planning to take:**
- PIC Enda Egan has been appointed as Chief Operations Manager for OCIL Ltd and centre PIC
### Proposed Timescale: 30/06/2015

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person put forward to be the person in charge did not have the necessary experience, qualification and skills to manage the designated centre.

**Action Required:**
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

**Please state the actions you have taken or are planning to take:**
- PIC Mr Enda Egan has been appointed as Chief Operations Manager for OCIL Ltd and centre PIC

### Proposed Timescale: 01/05/2015

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All documentation in relation to the nominated person in charge is in place had not been obtained.

**Action Required:**
Under Regulation 14 (5) you are required to: Obtain the information and documents specified in Schedule 2 in respect of the person in charge.

**Please state the actions you have taken or are planning to take:**
- Documentation in relation to current PIC has been obtained and forwarded to HIQA

### Proposed Timescale: 01/05/2015

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of clarity around the specific responsibilities of the provider nominee, the nominated person in charge, staff and other supervisors involved in the organisation.
**Action Required:**
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
- A management structure was drafted clarifying all responsibilities and will be confirmed following new recruits with relevant details of CNM 2, Nursing staff and Personal Assistants.
- All staff contracts to be revised and updated to reflect the services provided in centre and tasks required of employees in the centre.
- New Job descriptions have been devised in advance of recruitment process for candidates April 15

Organisational chart will be develop following new appointments

<table>
<thead>
<tr>
<th>Proposed Timescale: 29/05/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Leadership, Governance and Management</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The service on offer was not being effectively monitored to ensure it was safe and appropriate to meet residents needs.

**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:**
- A management structure will be drafted following recruitment of new personal in June 2015.
- Risk management PPPG ‘s has been drafted and a risk register created.
- Risk and incident management training due to take place on 17th June.
- The nominee provider/board of directors to complete unannounced audits to monitor safety, appropriateness, consistency and effectiveness of the service.

Develop protocols for unannounced inspections

<table>
<thead>
<tr>
<th>Proposed Timescale: 17/06/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Leadership, Governance and Management</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
There was no evidence of any staff appraisals or performance reviews being carried out in line with the centre's own policy.

**Action Required:**
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

**Please state the actions you have taken or are planning to take:**
- New PIC to complete appraisals in line with current policy.

**Proposed Timescale:** 01/05/2015

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There had been no unannounced inspections carried out to review the safety and quality of care.

**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:**
- Nominee provider/board of directors to complete unannounced inspections

Relevant documents to be completed
Develop protocols for unannounced inspections

**Proposed Timescale:** 17/06/2015

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

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient arrangements in place for the running of the centre in the absence of the nominated person in charge.

**Action Required:**
Under Regulation 33 (2) (b) you are required to: Give notice in writing to the Chief Inspector of the arrangements that have been, or are proposed to be, made for appointing another person in charge to manage the designated centre during that absence, including the proposed date by which the appointment is to be made.

**Please state the actions you have taken or are planning to take:**
- Notice in writing has been given to Chief Inspector about the recruitment of PIC

Organisational chart will be develop following new appointments.
Relevant job description currently under review

**Proposed Timescale:** 29/05/2015

---

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Delivery of care and support resource lead and not based on residents needs and wishes.

**Action Required:**
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
- Needs and wishes of the service user will be identified pre-admission or on day one of admission and categorised for priority in accordance with the Statement of Purpose

Statement of purpose, draft only at present, final document will depend upon negotiations with the HSE

**Proposed Timescale:** 12/06/2015

---

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff files were incomplete.

**Action Required:**
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.
<table>
<thead>
<tr>
<th>Proposed Timescale:</th>
<th>01/05/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme:</td>
<td>Responsive Workforce</td>
</tr>
</tbody>
</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was discrepancies between the hours that staff said they worked, and what was on the planned roster.

**Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
- PIC to complete a planned and actual roster.
- New CRM I.T system will be introduce to manage roistering and payroll if this system is not in place for the opening date we will be using a paper based system until new system is up and running.

<table>
<thead>
<tr>
<th>Proposed Timescale:</th>
<th>29/06/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme:</td>
<td>Responsive Workforce</td>
</tr>
</tbody>
</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no schedule of training available for inspectors. Documentary evidence for all training outlined in the previous action plan response was not available.

**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:**
- PIC to complete a planned and actual roster.
- New CRM I.T system will be introduce to manage roistering and payroll if this system is not in place for the opening date we will be using a paper based system until new system is up and running.

<p>| Proposed Timescale: | 15/06/2015 |</p>
<table>
<thead>
<tr>
<th><strong>Outcome 18: Records and documentation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Use of Information</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Policies and procedures as outlined in Schedule 5 were not in place

**Action Required:**
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
17/20 policies completed but need minor adaptations
3/20 being completed 22.may.2015

**Proposed Timescale:** 22/05/2015

| **Theme:** Use of Information |

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all documents as outlined in Schedule 4 were available in the designated centre, or for the review of inspectors.

**Action Required:**
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
Relevant documents to be completed:
- All documentation pertaining to schedule 4 will be available prior to opening of centre

**Proposed Timescale:** 12/06/2015

| **Theme:** Use of Information |

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff files did not contain the required information.

**Action Required:**
Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation
Please state the actions you have taken or are planning to take:
All new staff members files will be kept up to date as per regulations

**Proposed Timescale:** 01/05/2015