| Centre name: | A designated centre for people with disabilities operated by Clann Mor Residential and Respite Ltd |
| Centre ID: | OSV-0002099 |
| Centre county: | Meath |
| Type of centre: | Health Act 2004 Section 39 Assistance |
| Registered provider: | Clann Mor Residential and Respite Ltd |
| Provider Nominee: | Leo Connor |
| Lead inspector: | Ciara McShane |
| Support inspector(s): | None |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 22 |
| 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.
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

From: 29 October 2014 09:30
To: 29 October 2014 18:00

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>
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<tbody>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 08: Safeguarding and Safety</td>
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<tr>
<td>Outcome 18: Records and documentation</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

This was the first inspection carried out in the designated centre. The service provides care and support, including respite, residential and outreach services, to adults both male and female, whom have an intellectual disability. The designated centre consisted of nine units, eight of which were group homes and one which was an apartment.

On the time of inspection the person in charge and service manager were both available throughout the day. As part of the inspection the inspector reviewed documentation such as policies and procedures and spoke with staff and residents. The inspector found that residents were supported to live a life of their choosing, they told the inspector of their happiness with the service they received. The designated centre was well maintained and nicely decorated throughout. Resident's bedrooms were personalised and decorated to their choosing.

Areas for improvement were identified, including but not limited to the privacy and dignity of residents, risk management and policies relating to protection of vulnerable adults and managing resident's finances. These non compliances are discussed further in the report and outlined in the action plan at the end of the report.
Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The inspector was satisfied that resident’s rights privacy and dignity for the most part was maintained.

The centre had a complaints policy which was available to each resident in an accessible format throughout the designated centre. The inspector reviewed the detailed policy and found that it contained the principles of complaints detailing how complaints were received and managed. Further development of the policy was required to ensure the complaints officer was named and that their contact details were outlined in addition to a clearer appeals process. The policy failed to outline an independent appeals person should they not be satisfied with the outcome and not wish to appeal to a professional body.

Residents who spoke with the inspector were aware of their right to complain and told the inspector they would inform staff it they were unhappy or dissatisfied about elements of their service provision. Staff were found to be familiar with the complaints policy and told the inspector about forms they would complete if they received a complaint.

Residents had choice regarding their activities of daily living and how they spent their time. A number of residents completed their own grocery shop and planned their menus. A resident told the inspector they were not enjoying their day service and made the decision to leave it until a more favourable day service placement became available. The service supported the resident with their choice. Residents attended frequent residents meetings, the inspector reviewed sample minutes from these meetings and
was satisfied they were led by residents who actively participated in them.

Areas for improvement were identified in relation to privacy and dignity. As outlined in outcome 6 there was a bedroom situated adjacent to the kitchen and residents who availed of this room had to travel through the kitchen and lounge room in order to use bathroom facilities therefore compromising their privacy and dignity. One of the units also had a bathroom downstairs, with a frosted window, however the window opened out onto a walkway so other residents, staff and visitors had visibility into the bathroom when it was opened. This required a review.

**Judgment:**
Non Compliant - Moderate

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**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

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**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
The inspector found the designated centre to be well maintained, modern, clean and homely. The inspector saw the nine units, within the designated centre, and was satisfied for the most part they complied with the Regulations.

The inspector saw residents lived in homely environments with space to socialise with fellow residents, friends and family. Bedrooms were of sufficient size, personalised and had space for their personal belongings. Some residents had chosen double beds while others had single beds. The inspector saw paintings and photographs of family members and friends throughout the designated centre.

Residents told the inspector they had space to meet family and friends in private should they wish. Each unit, within the designated centre, had a sufficiently sized back-garden equipped with garden furniture, a shed and a covered gazebo for those who smoked. These areas were well maintained.

The designated centre was equipped with suitable laundry facilities and for the most part residents looked after their own laundry. Residents had access to equipped kitchens and for the most part cooked their own meals. A small number of the units required some additional assistance from staff with their laundry and meal preparation.
Residents had adequate access to bathrooms. A number of the bathrooms were equipped with Jacuzzi baths, residents told the inspector they enjoyed this aspect.

Each unit had a monitored alarm and secure safety chains and locks on their front doors. Residents told the inspector this made them feel safe.

Some improvements were required:

- One unit had a gate, at the top of the stairs, that was no longer required. The inspector showed this to the person in charge on the day of inspection and a staff member promptly removed the gate; the fixtures for the gate required to be removed.

- The flooring in the kitchen, of a unit, was bubbled and appeared to be loose, this required attention.

- A shower door was stuck and could not be opened at the time of inspection.

- There was a bedroom adjacent to the kitchen in one unit. The resident availing of this room had to access it from the kitchen but also had to walk through the kitchen and lounge room to access washroom facilities. This is further outlined in Outcome 1.

**Judgment:**
Non Compliant - Moderate

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**Outcome 07: Health and Safety and Risk Management**

_The health and safety of residents, visitors and staff is promoted and protected._

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
The inspector found, for the most part, that there were adequate systems in place to manage risk and to ensure residents, staff and visitors were safe however, improvements were identified to ensure compliance with the Regulations.

The centre had a fire safety management policy that outlined the provisions, arrangements and training in case of fire. The policy, although reference was made to the evacuation procedure, it was not outlined explicitly in the fire safety management policy. This required a review to ensure the policy was transparent and reflective of the actual fire safety management.

The inspector reviewed the health and safety statement which had been reviewed and updated October 2014. The health and safety statement outlined guidelines to assist
staff work in a safe manner. An emergency plan was not outlined in the health and safety statement, for example it failed to encompass the actions for staff to take should there be an emergency such as flooding or power outage. The health and safety statement also included the risk register. The risk register was held centrally at the designated centre and was generic to the general risks that staff, residents and visitors may be exposed to however it did not outline unit specific risks such as a specific trip hazard in one unit form the lounge room which stepped down into the kitchen. Each unit required a specific risk register that outlined the environmental risks for that area. The inspector also reviewed a sample of risk assessments found in residents care plans. Risk assessments, completed by care staff, were not consistently documented or detailed. Staff failed to identify the risk correctly in some instances therefore it was unclear what the actual risk was for the residents. The inspector also found that staff did not have suitable instruction on the completion of risk assessments. The person in charge stated this would be addressed. Improvements were required regarding the risk management policy as it failed to stipulate all requirements of the regulations regarding specific risks including the unexpected absence of any resident, incidents of self harm, aggression and violence.

The inspector found there were adequate systems in place to ensure residents and staff were protected from fire. Each unit had regular fire drills, approximately every six weeks. This was reflected in documentation reviewed by the inspector. The inspector also reviewed service records detailing the maintenance of emergency lighting, fire extinguishing equipment and fire alarm panels. Each unit had adequate smoke and carbon monoxide detectors. Residents and staff were both competent on how they would escape should the fire alarm sound, one resident showed the inspector where the fire assembly point was. Evacuation exits were found to be clear and unobstructed on the day of inspection. The inspector saw the evacuation plan was clearly displayed throughout the designated centre and each bedroom also had a copy of the evacuation procedure on the wall. All staff had up-to-date fire safety training.

Although the centre had a clearly defined colour coding system in place for food hygiene and for cleaning, the inspector identified areas for improvement regarding infection control:

- Bathrooms had surplus exposed toilet roll out of the packaging
- A wooden unit in one bathroom was chipped
- High risk chemicals were not safely secured
- A cleaning sponge with a scour was left under the taps of a bath and could be mistaken for personal use.

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

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The inspector found that there were adequate systems in place to ensure that residents were safe and protected from abuse however improvements were required to comply with the Regulations.

The centre had a policy on the protection of vulnerable adults developed June 2013. The policy required further development as it failed to outline the indicators of abuse and the types of abuse. It was also not reflective of the actual practice; the policy stipulated staff received ongoing supervision this is not accurate as only two senior staff members at the time of inspection received supervision. The policy also failed to outline who the designated officer was for the protection of vulnerable adults as further outlined in Outcome 18.

A large number of staff, thirty members, had up-to-date training on the protection of vulnerable adults and the inspector saw the remaining 19 staff were scheduled to receive the training on the 18th of November 2014. The inspector spoke with a number of staff throughout the inspection and was satisfied that staff could recognise signs of abuse and told the inspector they would report it to their manager if they had concerns. Staff also told the inspector about the form they were required to complete should they suspect, witness or receive an allegation of abuse. Residents told the inspector they felt safe and were confident if they had any concerns they would speak with staff. Residents told the inspector the house had an alarm helped them feel safe.

The inspector reviewed the finances for a sample of residents. Staff members checked the balance at the start of a shift and where two staff members were on duty two staff checked the balance also in the evening. Receipts were maintained for any purchases and itemised on a balance sheet for each resident. The inspector saw that the two balances checked were incorrect; there was surplus money from that outlined on the balance sheet. This required a review to ensure that the accounting system was robust. The guidelines in the policy regarding the security of individual accounts were unclear in relation to managing and reporting discrepancies in balances. The policy also failed to outline safeguards regarding staff assisting residents to withdraw sums of moneys from accounts for example there were no additional measures outlined for large sum withdrawals. This required review so that residents and staff were protected regarding
the safe management of residents monies. These non compliances are further outlined in Outcome 18. Residents told the inspector they had bank accounts and staff assisted them where required. Residents were also supported by staff to make purchases and collect allowances from their local post office.

**Judgment:**
Compliant

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**Outcome 18: Records and documentation**
*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**
Use of Information

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
Improvements were required regarding records and documentations to comply with the Regulations.

The provider had developed and implemented a range of policies and procedures to guide staff in the delivery of services to residents and the running of the centre. The inspector reviewed a sample of these policies. Some of the policies reviewed did not provide sufficient direction to staff or outline clear procedures. For example the policy on managing resident's finances failed to provide guidance on the management of discrepancies or guidance on the managing of withdrawals involving large sums. The policy of the protection of vulnerable adults also required further development as it failed to outline the types and indicators of abuse in addition to naming the designated officer for the protection of vulnerable adults.

**Judgment:**
Non Compliant - Minor
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:**

Ciara McShane  
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 Clann Mor Residential and Respite Ltd</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002099</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>29 October 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>24 November 2014</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:

Improvements were required regarding the layout of:

- A downstairs bathroom in one unit.
- A bedroom in a unit where the resident had to walk through a kitchen and lounge room to access bathroom facilities.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
Actions:
• The current frosted window which opens outwards onto a walkway will be removed completely and replaced with a similarly frosted window that
  o Opens outwards at the top
  o Can be opened by service users from the inside
  o Is situated above head height from the outside so that people cannot see into the bathroom
2: Improvements were required regarding the layout of a bedroom in a unit where the resident had to walk through a kitchen and lounge room to access bathroom facilities.
Actions:
• A registered building contractor visited this premises on 10.11.2014 to assess the current physical layout and propose an alternative solution.
• The proposed solution will create direct access from the bedroom to the hall where the bathroom is located. The existing door from the bedroom to the kitchen will be removed, and the space will be blocked up completely. This solution will include any associated electrical/plumbing work that may be required. A quotation for the above works was received on 12.11.2014.
• Quotations will be sought from two further contractors.
• The Person in Charge will meet with the HSE on 21.11.2014 with regard to securing funding for the above works.

Proposed Timescale: 30/01/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear in the complaints policy who the nominated complaints officer was and how they could be contacted.

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:
• Policy document Responding to Complaints will be amended to include a named person as the nominated complaints officer, and details about how they can be contacted.
• The easy-read service user complaints document in all houses will be amended to
propose changes to Responding to Complaints.  

- Both documents will be reviewed and approved by all Clann Mór staff team members at our next Quarterly Meeting on 02.12.2014.  
- Both documents will be reviewed and signed off by the Board of Directors at the next Board of Directors meeting on 03.12.2014.  
- Copies of both amended documents will subsequently be distributed to all service delivery locations, service users and staff team members. 

**Proposed Timescale:** 09/12/2014  
**Theme:** Individualised Supports and Care  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Further clarification was required in the policy outlining the appeals person and details of the independent appeals person.  

**Action Required:**  
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.  

**Please state the actions you have taken or are planning to take:**  
Actions:  
- Policy document Responding to Complaints will be amended to remove the reference to HIQA as a suitable independent appeals person and replace it with a reference to the HSE (Consumer Affairs Department), and details about how the HSE can be contacted in the event that an individual is not satisfied with the response to a submitted complaint.  
- The easy-read service user complaints document in all houses will be amended to reflect the proposed changes to Responding to Complaints.  
- Both documents will be reviewed and approved by all Clann Mór staff team members at our next Quarterly Meeting on 02.12.2014.  
- Both documents will be reviewed and signed off by the Board of Directors at the next Board of Directors meeting on 03.12.2014.  
- Copies of both amended documents will subsequently be distributed to all service delivery locations, service users and staff team members.  

**Proposed Timescale:** 09/12/2014
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 flooring in the kitchen, of a unit, was bubbled and appeared to be loose.

A shower door was stuck and could not be opened at the time of inspection.

**Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
1: The flooring in the kitchen, of a unit, was bubbled and appeared to be loose.
   Actions:
   • On 27.11.2014 the bubbled and loose flooring was removed completely and replaced with new flooring. Completed on November 27th 2014.
2: A shower door was stuck and could not be opened at the time of inspection.
   Actions:
   • The existing closing mechanism will be removed completely and replaced with a simplified mechanism which will facilitate simple access and egress to/from the shower. Completed on November 27th 2014.

**Proposed Timescale:** 27/11/2014

Outcome 07: Health and Safety and Risk Management

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy failed to outline the measures and actions in place to control the unexpected absence of any resident.

**Action Required:**
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

**Please state the actions you have taken or are planning to take:**
• Measures and actions in place to control the unexpected absence of a resident are outlined in an existing, separate policy document Absconion.
• The existing section of policy document Risk Management, will be amended to include a reference to Absconion.
• This document will be reviewed and approved by all Clann Mór staff team members at our next Quarterly Meeting on 02.12.2014.
• This document will be reviewed and signed off by the Board of Directors at the next
Board of Directors meeting on 03.12.2014.
• Copies of this document will subsequently be distributed to all service delivery locations.

Proposed Timescale: 09/12/2014
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy failed to outline the measures and actions in place to control aggression and violence.

Action Required:
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
• The Person in Charge has arranged a one-day planning meeting with an external quality and safety specialist for 04.12.2014. This meeting will be attended by the management team and will cover all aspects of risk management within the organisation, to include measures and controls to control aggression and violence.
• Policy document Risk Management will be amended accordingly.
• Amendments and/or any new documents developed, will be distributed to all staff teams for review in all service locations in January 2015.
• All additional/amended documents will be reviewed and signed off by the Board of Directors at the Board of Directors meeting on 14.01.2015.
• Copies of all additional/amended documents will subsequently be distributed to all service delivery locations.

Proposed Timescale: 21/01/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy failed to outline the measures and actions in place to control self harm.

Action Required:
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
• Measures and actions in place to control self-harm are outlined in an existing, separate policy document Meeting the Needs of Service Users at Risk of Self-Harm.
• The existing section of policy document Risk Management, will be amended to include
a reference to Meeting the Needs of Service Users at Risk of Self-Harm.
• This document will be reviewed and approved by all Clann Mór staff team members at our next Quarterly Meeting on 02.12.2014.
• This document will be reviewed and signed off by the Board of Directors at the next Board of Directors meeting on 03.12.2014.
• Copies of this document will subsequently be distributed to all service delivery locations.

**Proposed Timescale:** 09/12/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The system in place to manage all risk required review as risk assessments were not specific to each unit, in particular the risk register. In addition all risks had not been clearly identified or controls documented to reduce the risk.

The safety statement did not outline emergency planning.

**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:**
1: The system in place to manage all risk required review as risk assessments were not specific to each unit, in particular the risk register.
Actions:
• A new, separate risk register will be created for each individual service delivery location.

2: All risks had not been clearly identified or controls documented to reduce the risk.
Actions:
• At the Community Facilitator meeting on 06.11.2014, a document was distributed to all staff teams to clarify how to correctly identify risks, i.e. how to identify the actual risk, as opposed to just the risk activity, and also a document to identify and document actual, current risks for all service users, to be completed by all staff teams. This information will be used for risk management planning and training purposes.
• The Person in Charge has arranged a one-day planning meeting with an external quality and safety specialist for 04.12.2014. This meeting will be attended by the management team and will cover all aspects of risk management within the organisation, to include the scheduling of specific risk management training for the Management Team and the Community Facilitator team in January 2015 (date TBC), which will subsequently be shared and implemented in all service locations.

3: The safety statement did not outline emergency planning.
Actions:
• Measures and actions in place to respond to emergencies are outlined in an existing, separate policy document Management of Internal Emergencies.
Proposed Timescale: 31/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required regarding infection control:

- Bathrooms had surplus exposed toilet roll out of the packaging
- A wooden unit in one bathroom was chipped
- High risk chemicals were not safely secured
- A cleaning sponge with a scour was left under the taps of a bath and could be mistaken for personal use.

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

Please state the actions you have taken or are planning to take:
1: Bathrooms had surplus exposed toilet roll out of the packaging.
Actions:
  • On November 21st, a memo was distributed to all service locations to outline that no surplus unpackaged toilet roll should be kept exposed in any bathrooms, and that surplus toilet roll should be kept in an enclosed unit (if present), or enclosed in a suitable covering to prevent exposure.

2: A wooden unit in one bathroom was chipped.
Actions:
  • This unit will be removed completely, and if necessary, replaced with a new unit. By December 5th 2014.

3: High risk chemicals were not safely secured.
Actions:
  • On 26.11.2014, locks were fitted to all storage units under kitchen sinks in all service locations, for the purpose of keeping all high risk chemicals secured.

4: A cleaning sponge with a scour was left under the taps of a bath and could be mistaken for personal use.
Actions:
  • On November 21st, a memo was distributed to all service locations to outline that any items which are used in any cleaning processes, should be stored securely with cleaning products, and not left accessible at cleaning sites in any service location.

Proposed Timescale: 05/12/2014
Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policies regarding the management of resident’s finances and the protection of vulnerable adults required further development as outlined in the body of the report.

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:
• The existing policy document SS-PP-9 Security of Service User Accounts and Personal Property will be amended to include measures and controls to manage discrepancies, and also measures and controls to manage withdrawals of large sums of money.
• This document will be reviewed and approved by all Clann Mór staff team members at our next Quarterly Meeting on 02.12.2014.
• This document will be reviewed and signed off by the Board of Directors at the next Board of Directors meeting on 03.12.2014.
• A copy of this amended document will subsequently be distributed to all service delivery locations.

2: The protection of vulnerable adults required further development as outlined in the body of the report.

Actions:
• In addition to the measures and controls outlined in existing policy document Safeguarding and Protection from Abuse, further measures and actions in place for the protection of vulnerable adults, specifically the types and indicators of abuse, are outlined in an existing, separate policy document Responding to Allegations of Abuse.

Proposed Timescale: 09/12/2014