Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Peter Bradley Foundation Limited
Centre ID:	OSV-0001522
Centre county:	Cork
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Peter Bradley Foundation Limited
Provider Nominee:	Stevan Orme
Lead inspector:	Mary O'Mahony
Support inspector(s):	Noelle Neville
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 inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
07 December 2015 09:30	07 December 2015 18:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The Health Information and Quality Authority's (HIQA or the Authority) third inspection of this centre was unannounced. As part of the inspection, inspectors met with residents, the person in charge, the social care leader and rehabilitation assistants. Inspectors spoke with the person in charge and discussed the management and governance arrangements for supporting staff in their roles. Inspectors reviewed the policies and procedures in the centre and examined documentation which covered issues such as medication management, accidents and incidents, personal plans, staff files, policies and training records. Inspectors noted that there had been adequate and sufficient actions taken in response to findings of non compliance on the previous inspection. On the day of inspection staff were noted to be competent and calm while residents were seen to be happy and content in their environment.

On the day of inspection there were five residents in the centre. While the inspection was in progress the residents were seen to be going out to attend appointments, to go to various centres for their rehabilitative programmes and to be engaged in their

various allocated duties in the house.

The action plan at the end of the report identifies areas where some improvements were needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities. Improvements were required in the areas of health and safety and risk management, fire safety, premises and staff training.

Since the previous inspection the centre has received notice that funding for a newly built residence had been granted. This proposal was with the national office of the organization and had yet to be accepted. The CEO of the organisation informed the Authority that the amount received was not sufficient and negotiations were ongoing. The person in charge was aware of the unsuitability of the current premises and stated that all residents were looking forward to the new residence which was to be purpose built for their needs. However, there had been no plans or time line for the proposed works forwarded to the Authority to date.

An immediate action plan was issued to the provider on fire safety management systems in the centre. A satisfactory response to this was received within the time frame specified by the Authority and fire safety works were addressed.

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors noted that the rights of residents were supported by staff in the centre. There was a regular consultation process in place which the person in charge said was adapted to residents' needs. The person in charge explained how residents accessed advocacy services.

An easy-to-read version of the complaints procedure for residents and their representatives was prominently located in the entrance hall. The name of an independent nominated person was displayed. Staff and residents with whom inspectors spoke were aware of how to initiate the process. However, accessibility issues for wheelchair users in the house had not been resolved. Inspectors observed that the house was not wheelchair friendly and in addition, the location of the house on a hill meant that access the local town was problematic, particularly for anyone who used a wheelchair.

The centre had five residents' bedrooms and one staff bedroom. There were large wardrobes, shelving and locked storage facilities available for each resident. There were two 'sleepover' staff on duty each night. One staff member slept over in the sitting room from 23.30hrs. This arrangement impacted on the residents' access to the sitting room from 23.00 onwards. There was no separate visitors' room. However, the person in charge stated that funding had been secured and a site for a proposed purpose-built house had been identified. This issue was further addressed under Outcome 6: Premises.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
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.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Contracts of care set out the service to be provided in the designated centre and were signed for each resident.
The admissions policy now set out criteria to protect residents from peer abuse as required by Regulation 24 (1) (b).

Judgment:
Compliant

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:
Findings under this Outcome remained unchanged from the findings of the previous inspection. Space in the narrow downstairs hallway was seen to be restricted by the storage of equipment and boxes in the open under stairs area. The narrow doorways and corridors remained unsuitable for any residents who had mobility issues. In addition, the narrow hallways impacted on residents with behaviour difficulties as there was little space to pass other residents. Space in the upstairs corridor was also restricted. Furniture, shelving for books and paperwork, boxes and equipment were stored in this area. There was a wheelchair ramp outside the front door. However, it did not provide adequate accessibility to the centre due to the steep slope as the premises was located on a hill.

There was no bath in the centre. Furthermore, one downstairs toilet and shower room had a strong unpleasant odour. This was addressed while inspectors were on the premises. The shower up-risers in the showers had been replaced since the previous inspection and there were soap dispensers readily available.

As found on the previous inspection there was a communal sitting room and open plan dining room/ kitchen area in the centre. However, inspectors formed the view that this space was inadequate for these residents. Due to complex needs and their differing personalities they required more private space, a visitors' room and recreational space outside of their bedroom. There was no separate toilet area or changing room for staff.

Inspectors spoke with the person in charge who stated that the present house was rented and not suitable for all residents' needs. However, the person in charge stated that funding had been secured and a suitable site for a proposed purpose-built house had been identified in the area. This proposal was currently with the national office for the organisation. The person in charge stated that she was hopeful that the decision would be made to proceed with the building in the near future. However, the CEO for the organisation informed the inspector that the funding was not sufficient for the proposed building and negotiations were still ongoing. A time bound, costed, specfic plan had yet to be received by the Authority.

Judgment:
Non Compliant - Major

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:
The provider was issued with an immediate action plan on the inadequate fire management arrangements in the centre. A satisfactory response was received by the Authority within the timeframe specified by the Authority.

Risks not addressed since the last inspection included:

There was no fire panel to support staff in locating the source of a fire. There was no emergency lighting in place in the centre.
The centre did not have a fire compliance certificate available from a suitably qualified person in the area of fire safety.

Fire prevention precautions and controls for non-compliant smokers needed to be more robust in the area of risk assessment and controls.
Infection control procedures were not adequate.

Findings on this inspection:
The centre had a health and safety statement and it was relevant to the centre. Procedures were in place for the prevention and control of infection. However, these were not sufficiently robust particularly as there was a resident in the centre with a particular ongoing infection. For example, the guidelines for cleaning and prevention of cross contamination had been updated since the previous inspection. However, there was a discrepancy noted in the documentation available to staff as regards the correct temperature required for washing the clothing of this person. This was rectified during the inspection. In addition, similar to findings of the previous inspection there was no separate staff toilet and changing area for the two sleepover staff, again in view of the particular infection present. Taking into consideration the needs of residents and the presence of an infection in the centre inspectors formed the view that separate facilities were necessary for staff, for infection control purposes as well as for the privacy and dignity of residents. This was addressed under Outcome 6: Premises. Nevertheless, there were alginate bags available for the segregation of laundry in the event of an outbreak of infection. Housekeeping and laundry duties were carried out by staff and residents in the centre and the laundry was equipped for the needs of the centre. There were coloured coded systems in use for floor washing and food preparation. The person in charge said that senior staff had received training in food safety and documentation was viewed which confirmed this.

The centre had a risk management policy and a risk register which contained risk assessments for potential risks associated with the centre. However, not all risks in the centre had been identified and assessed. These included the large unrestricted open windows on the ground floor and individual risk assessments for residents who smoked. An emergency plan was in place in the centre and a safe placement for residents in the event of an evacuation had been identified. Regular fire drill training was documented and there were personal evacuation plans for residents. However, a staff member informed inspectors that she had never been present at a fire drill and one staff stated that she had yet to undertake fire training. There was evidence that arrangements were in place for daily checking of fire precautions which included the fire exits. Residents tested smoke alarms weekly. Inspectors noted that fire exits were unobstructed. Staff spoken with by inspectors were aware of what to do in the event of a fire. The procedure was also displayed in the hallways to increase awareness.

Residents had individual fire evacuation and emergency plans (PEEPS) on display in their bedrooms. However, there was no centralised fire alarm system or adequate emergency lighting in place as had been recommended on documentation seen by inspectors, by an external, suitably qualified person. This was particularly significant as inspectors noted that there were three residents who smoked in the centre and there had been previous incidents of residents smoking in their bedrooms. One resident still went out at night to smoke while staff were sleeping, which presented a major risk. For example, one resident who smokes had had a seizure during the night. He had been attended promptly by staff. However, inspectors formed the view that the risks attached to having two sleepover staff remain high and the person in charge was asked to review this risk

at regular intervals. This arrangement had not been comprehensively risk assessed for example, unsupervised night time smoking, environmental risks, the possibility of the doors being left open and other more immediate risks.

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The person in charge informed inspectors that she was actively involved in the management of the centre. There was also a social care leader who was on duty each day. The person in charge stated that she was aware of her obligation to report any allegation of abuse to the Authority.

Residents spoken with by inspectors said that the staff were kind and inspectors observed interactions between staff and residents which demonstrated a respectful attitude. They said they felt safe in the centre. The person in charge stated that safeguarding plans for residents, where required.

There was a policy on the management of allegations of abuse which had been updated since the previous inspection. There was a named person identified as the person responsible for investigating allegations and the responsibility to report any allegation to the Authority was documented. The person in charge informed inspectors that staff were reading the new HSE guidelines for the safeguarding of vulnerable persons at risk published in December 2014. Training records indicated that staff had received training on the prevention and detection of abuse. However, one staff member had yet to receive this training. This was addressed under Outcome 17: Workforce. Residents were aware of the name of key workers and understood that they could access an advocate and were familiar with the concept of advocacy. There was a folder on advocacy services on the table in the sitting room.

There was a policy on restrictive interventions which outlined measures to promote a restraint free environment. The policy listed alternative measures to the use of restraint. Staff had received training in positive behaviour support. However, a number of staff

were yet to complete this course which was seen to be scheduled. This was addressed under Outcome 17: Workforce. The person in charge informed inspectors that all training was reviewed annually. There was also a policy on behaviour that challenges and this contained details of support for both residents and staff in understanding behaviour issues. Inspectors found that the measures in place for the management of residents' finances were robust. Records were made of transactions conducted by and on behalf of residents. They were signed by two staff members or by the resident and one staff member. Residents in general, had control over their finances and were appropriately supported in budgeting their finances by staff members.

Judgment:
Compliant

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

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
A record of all notifiable incidents was maintained in the centre and all incidents were notified to the Authority in line with the requirements of Regulations.

Judgment:
Compliant

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Residents had access to general practitioner (GP) services and appropriate therapies such as dietician, podiatry, physiotherapy, and dentist. There was evidence in residents'

notes that access to specialist consultants was organised and facilitated to meet the medical needs of the residents. The person in charge confirmed to inspectors that access to the occupational therapist (OT), speech and language therapist (SALT) and the psychologist had increased since the previous inspection.

The centre focused on neuro-rehabilitation and staff spoken with by inspectors explained that residents had an individual rehabilitation plan (IRP) which was reviewed annually and more often when required. Residents were supported to identify and fulfil their goals by their key-worker, who was their rehabilitation assistant (RA). Documentation to support this was viewed by inspectors.

Inspectors noted that residents were supported to make healthy living choices. Visits to the gym were facilitated by staff and healthy eating plans were in place for some residents, as recommended by the dietician. Adequate stores of fresh and frozen food, refreshments and snacks were in place in the kitchen. Residents informed inspectors that there was a choice available to them and that menu plans for the week were developed on a Sunday, in consultation with residents. Some residents shopped independently. Inspectors observed that staff were aware of the healthcare and social needs of residents in the centre. The individual routines and supports required by residents were outlined and documented in detail.

A detailed end of life care plan was completed for each resident and documented in their notes. Minutes of multidisciplinary team meetings and case review meetings were viewed by inspectors. Residents with behaviours that challenge were appropriately supported by the relevant team members. Updated care plans were seen to be in place for residents and residents were supported to attend their GP on a regular basis.

Judgment:
Compliant

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The medication management policy was last reviewed in June 2105. Staff spoken with by inspectors had been trained in the administration of buccal midazolam for the management of seizure activity. Medications were securely stored.

Medications were supplied by the pharmacy in blister pack systems and regular reviews of prescriptions by the GP were apparent in residents' care plans. Inspectors noted that

a medication administration and prescription booklet were in place for each resident. Photographic identification was in place for each resident. There was a tablet identification sheet for all medications administered. Protocols for the administration of PRN (as required) medications were in place in the residents' prescription folder. Seizure records and a portable medical profile, to support hospital admission were in place, where appropriate. Residents were facilitated to meet with the pharmacist on their visit to the pharmacy to collect their medication.

One resident was responsible for the self-administration of their 13.00 medications. An appropriate risk assessment had been conducted and a weekly review was conducted by staff with the resident.

Inspectors reviewed medication audit reports conducted in the centre. There was evidence to support learning from the results of audits. This was seen to be documented in the minutes of staff meetings.

Judgment:
Compliant

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors reviewed the statement of purpose and found that it contained all requirements of the Regulations. It was kept under annual review and was available in a format accessible to residents.

The statement of purpose contained adequate information on the management of complaints in the centre. There were posters prominently displayed in the centre which outlined the complaints process. An alternative complaints process was also identified for residents.

Judgment:
Compliant

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:
Every effort was made by staff to support residents to meet their goals, go on holidays, visit their homes and go to various activities and concerts. Residents confirmed this with inspectors.

Inspectors noted that facilities and services available in the centre reflected those outlined in the statement of purpose. Sufficient staff were noted to be present during the inspection to support residents with their daily needs and activities. However, staff with whom inspectors spoke stated that occasionally they were short staffed if a staff member went on sick leave or was unavailable. For example, one staff member had been on sleepover duty at the weekend on his own. Another staff member stated that when there were only two staff on duty this created difficulties for staff if a conflict situation occurred between residents. However, the person in charge stated that staff unavailability did not occur on a regular basis. She stated that the she was available to cover a shift when they were short staffed and that the social worker had completed a shift also, when required. She also explained that not all residents were in the house at weekends as some residents went home to family members.

Judgment:
Compliant

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:

A sample of staff files reviewed by inspectors complied with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013. Records reviewed indicated that most staff had attended a range of training to include the mandatory training required by Regulations. The person in charge informed inspectors that training needs of staff were assessed annually and that training could also be provided on an individual basis if the need arose. However, not all staff had appropriate training relevant to their role. For example, not all staff had completed the training session in positive behavioural support and a staff member had not attended training in the prevention of elder abuse. Inspectors viewed the schedules for the proposed training provision.

Staff were supervised according to their role. Rosters were planned to meet the needs of the residents. Inspectors viewed the worked roster and planned roster. Staff were able to demonstrate an awareness of the centre's policies and had access to a copy of the Regulations and the National Standards. There was continuity of rehabilitation staff for the residents and staff with whom inspectors spoke were qualified and experienced. Supervision, probationary meetings and appraisal of staff were ongoing according to the person in charge. All staff members had five supervision sessions in the year. Supervision documentation was reviewed by inspectors.

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The majority of records listed under Part 6 of the Health act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were maintained in the centre. Inspectors noted on this inspection that medication errors had been recorded. Accurate records of charges to residents were maintained. Notifications had been made to the Authority and records of these

notifications were available.

The designated centre was adequately insured against accidents or injury to staff, residents and visitors. This document was viewed by inspectors.

The centre had polices in place as required under Schedule 5 of the Regulations. Policies and procedures had been reviewed and updated since the previous inspection. The HSE guidelines on infection control were available in the centre and the new HSE safeguarding guidelines for vulnerable adults 2014 were available and read by staff. Not all policies were centre specific, such as, the complaints policy and the medication policy. However, local protocols were available with the organisation policies.

Judgment:
Substantially Compliant

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:

Mary O'Mahony
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Peter Bradley Foundation Limited
Centre ID:	OSV-0001522
Date of Inspection:	07 December 2015
Date of response:	10 February 2016

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 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to provide premises which were designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

1. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed

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

and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
New accommodation measures are being reviewed. Funding of €400,000 has been accessed through the Cork Co Council for the development of a new premises. This is project is currently being reviewed with Corporate Services Director

Actions taken so far:
• Inspector notified of success with CAS funding – 23/7/15
• Documentation confirming success in accessing funding forwarded-18/8/15
• Email forwarded by Regional Manager ABI-Ireland seeking clarification of project start to Corporate Services Manager – 20/1/16

Proposed Timescale: D Buckley Board member lead for macroom project will meet with Cork Co Council by 29/2/16 with a view to breaking ground on project by November 2016.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The location of the house at the top of a steep hill did not afford maximum accessibility for residents. The stairs and narrow hallways were problematic for residents' requiring wheelchairs.

2. 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:
1. New accommodation measures are being reviewed. Some funding has been accessed through the Cork Co Council for the development of a new premises. This is project is currently being reviewed with ABI-Ireland Housing development Manager.

Actions taken so far:
• Inspector notified of success with CAS funding – 23/7/15
• Documentation confirming success in accessing funding forwarded-18/8/15
• Email forwarded by Regional Manager seeking clarification of project start to corporate services director – 20/1/16

Proposed Timescale: D Buckley Board member lead for Macroom project will meet with Cork Co Council by 29/2/16 with a view to breaking ground on project by November 2016.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All the requirements of Schedule 6 of the Regulations had not been met.

3. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
Schedule 6
• Items 1-5 will need to be addressed under new project development for Residential Service
• 6- Adequate heating, lighting and ventilation in current accommodation is in situ
• 7- There is sufficient space in kitchen area but this is not separate to the dining area in current accommodation – this will be addressed through the new development.
• 8- Current level of showers and bathing area will be reviewed through new development.
• 9- there is a suitable arrangement in place for safe disposal of clinical waste which is managed through local health centre
• 10-There are adequate facilities in place for launder of resident's clothes and residents have assigned for private use of washing machine.

Proposed Timescale:

Schedule 6:
1. 1-5 – Proposed Timescale: D Buckley Board member lead for macroom project will meet with Cork Co Council by 29/2/16 with a view to breaking ground on project by November 2016.

2. 8- Proposed Timescale: D Buckley Board member lead for macroom project will meet with Cork Co Council by 29/2/16 with a view to breaking ground on project by November 2016.

Proposed Timescale:

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:
Not all risks in the centre had been assessed and suitable controls had not been put in place to mitigate those risks.

4. 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:
1. Local Risk assessment policy is being developed for each of the mandatory risk areas of
-Unexpected absence of a person served
-Accidental injury to a resident, visitor of staff member
-Aggression and violence
-Self-Harm.

Actions taken:
2. Email forwarded to – executive outlining the requirements on control measures for national policy on risk assessment on 7/12/16
3. Risk assessment for unrestricted open windows on ground floor completed 12/15
4. Review of individual risk assessments for residents to be updated.

Proposed Timescale:
1. To be completed by 26/2/16
2. Completed 7/12/16
3. Immediate by 8/2/16
4. Immediate by 8/2/16

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Infection control procedures were not robust in relation to infection in the centre.

5. 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. Safe storage unit for dust pan and sweeping brush for resident room being reviewed

Action Taken:

2. Easy to read version of infection control protocol with summary on Hep C/What to do in the event of an emergency/safe disposal of sharps/safe transfer of laundry/infection control guidelines
3. Infection control protocol for the safe cleaning of residents room and storage of cleaning items
4. Installation of hand wash dispenser, toilet roll holder and gel sanitizer

Proposed Timescale:
1. New unit to be purchased - 26/02/16
2. Completed 26/1/16
3. Completed initiated 8/11/11 – reviewed 23/6/15 & 8/12/16
4. Completed 17/12/15

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective fire management systems were not in place.

6. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
1. LD1 fire safety system in place since 21/12/15
2. Additional fire extinguishers installed by ABLE Fire protection November 2015

Proposed Timescale: 21/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all fabric and bedding in the bedrooms of residents who smoked was fire safe. This was significant as a small burn was noted on a bed sheet.

7. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
1. Bedding and sheets audit to be completed, any items that need replacing to be assessed as fire safe.

2. Smoking agreements in place for clients who smoke and no smoking policy applies with house.
3. Fire LD1 system in place as of 21/12/15

Proposed Timescale:

1. Immediate – to be completed by 5/02/16
2. Completed – Agreements in place since: behaviour support plan smoking – 9/7/14, smoking agreement 14/1/14, fire safety plan smoking in evening and during night 17/6/14, safe storage of cigarettes in car – 6/2/14
3. Completed – 21/12/15

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate means for detecting fires were not available.

8. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
1. Refresher fire safety training for residents with ABLE Fire Protection
2. LD1 Fire system installed by safety Fire Tech 21/12/15
3. Fire Drill Safety awareness workshop and presentation completed with residents 10/12/15 – this item will be on each monthly agenda for residents meetings.

Proposed Timescale:
1. Fire Safety Training scheduled for 25th of February 2016 with ABLE Fire Protection
2. Completed – 21/12/15
3. Completed – 10/12/15

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had attended training in fire safety and all staff had not attended fire drills.

9. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive

suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
1. Refresher Fire Safety Training to be completed with all staff with ABLE Fire Protection – currently being reviewed with ABI-Ireland Training Dept
2. Schedule of Fire Drill facilitation has been completed to ensure all staff will complete fire drills with residents monthly over the year.

Proposed Timescale:

1. Fire Safety Training scheduled for 25th of February 2016 with ABLE Fire Protection
2. Completed – 26/1/16

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had completed mandatory training such as the management of behaviour that challenges and a staff member had not attended training in the prevention of elder abuse.
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10. 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:
1 Training of vulnerable adults for all staff
2 Updated training of MAPS
3 Ongoing refresher training as per mandatory requirements is delivered on an annual basis

Proposed Timescale:
1. Training scheduled for staff from 8th -10th of March 2016
2. Training scheduled for staff from 8th -10th of March 2016
3. 01/12/16

Proposed Timescale:

Outcome 18: Records and documentation
Theme: Use of Information **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Not all policies in the centre were specific to the centre. **11. 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:** Review and update of schedule 5 policies in relation to complaints and medication for local policy and ensure centre specific guidelines.
Proposed Timescale: 26/06/2016