

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Ard Na Greine
Centre ID:	OSV-0001522
Centre county:	Cork
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Peter Bradley Foundation Company Limited by Guarantee
Lead inspector:	Caitriona Twomey
Support inspector(s):	None
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

From: 10 January 2018 10:45 To: 10 January 2018 19:50

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

Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This unannounced, one day inspection was carried out to monitor compliance with the regulations and standards and to follow up on matters from the previous inspection. It was the fifth inspection of this centre carried out by the Health Information and Quality Authority (HIQA). The last inspection took place in November 2016. Since the last inspection, Acquired Brain Injury Ireland had submitted a notification indicating its intention to cease to carry on the business of the designated centre and to close the centre. This was in keeping with a prior commitment from the organisation to provide more appropriate accommodation for residents. In November 2017, this notification was withdrawn.

Description of the service:

The centre was a detached, five bedroom house, located less than two kilometres from a town in county Cork. Five residents were accommodated in single occupancy bedrooms. Four bedrooms were located on the ground floor and one upstairs. The centre had two bathrooms, one on each floor, both equipped with a shower. There was a utility area located off the kitchen. There was a staff office with an inner staff bedroom upstairs in the centre. The communal areas of the house comprised of an open plan kitchen and dining area, and a sitting room. Residents also had access to a garden. The centre was warm, homely, tidy and well maintained.

Both male and female residents lived in the centre. The centre had two vehicles which were used to support residents to regularly access their local community,

spend time with family members, attend various classes and day services, and attend appointments, as required. The centre was staffed 24 hours a day, seven days a week.

How we gather our evidence:

As part of the inspection, the inspector met with the five people living in the centre, the person in charge, the team leader in the centre, and three other members of the staff team. The inspector reviewed documentation including training records, fire safety information, supervision and performance management records, reports completed by the provider following an unannounced inspection of the centre, and the centre's most recent annual review.

Overall judgment of our findings:

The residents reported that they were happy living in the centre, were happy to meet with the inspector, and appeared comfortable with staff and in their surroundings. A number of residents expressed a clear preference to live in their own homes and hoped they would achieve this in the future. All residents spoke positively regarding the staff working in the centre. All interactions between staff and residents observed during the inspection were respectful and supportive. The staff team appeared to have a very good knowledge of the residents' complex needs and a shared belief regarding the importance of supporting residents' independence wherever possible.

The centre was inspected against five outcomes. The findings of this inspection were consistent with those outlined in previous reports regarding the unsuitability of the premises based on the assessed needs of the residents. This resulted in a finding of major non-compliance in Outcome 6: Safe and suitable premises. Moderate non-compliances were identified due to the use of an inner room as a staff bedroom (Outcome 7: Health and Safety and Risk Management) and, despite promising plans in the interim, the ongoing absence of a clear, time bound plan to source an alternative, suitable premises for the residents (Outcome 14: Governance and Management).

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 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:

The centre was clean, warm and decorated in a homely manner. The hallway and doorways were narrow, however the resident who used a wheelchair was observed to mobilise independently when in the centre. There was limited communal space in the centre. This had been highlighted on previous inspections, however since the last inspection an additional resident had moved in. The centre had one sitting room. As such there was no area, other than their bedrooms, where residents could receive visitors in private. In addition, the sitting room was used nightly as a staff sleepover room. The provider had previously informed HIQA of its intention to source a more appropriate premises. However on the day of inspection there was no clear, time bound plan as to how, and when, this would be achieved.

The team leader provided the inspector with a document she had compiled in January 2018 regarding each of the residents' accessibility needs. The purpose of this document was to advise senior management within the organisation of residents' needs to facilitate the sourcing of appropriate, alternative accommodation. This document outlined that each of the five residents required access to a wet room. This was not available in the current property. The document also outlined that four of the residents either struggle with, or should avoid, steps and stairs. This included the one resident whose bedroom was upstairs in the centre. The document stated that the fifth resident required a fully wheelchair accessible property. It was also outlined on this document, and verbally to the inspector that due to a diagnosed medical condition, one resident would likely require a hoist in the future. There were concerns expressed by staff about the capacity to accommodate this equipment in the confines of the current premises.

During the inspection the inspector observed all five residents moving independently throughout the building, without assistance. This included observation of one resident

using the stairs. Although other residents were not prevented from accessing the upstairs area, the team leader reported that they were encouraged to stay on the ground floor of the centre. She further reported that there was always at least one member of staff downstairs. It was observed during the inspection that while all residents could independently exit the centre, one resident required staff assistance to re-enter the building. The person in charge outlined enquiries she had made regarding sourcing improved ramps to support access to the centre and a covered outside area. This process was complicated by the uncertainty regarding the tenancy of the property.

The team leader outlined the various measures that have been undertaken to adapt the current premises. She spoke about how furniture had been rearranged to facilitate all doors to open fully and to create more space in one of the bedrooms. She also outlined the various in-house routines and community based activities that residents participate in outside of the centre and the consideration of these when planning other activities and appointments so that each resident accessed the community regularly. She also reported that residents' preferences were to eat at different times so mealtimes were often staggered in the centre. In addition, two of the five residents preferred to watch the television in their bedrooms rather than in the communal sitting room.

Through conversation with the team leader it was identified that the sitting room also functioned as a sleepover room for a staff member every night. The inspector enquired about incidents where a resident may wish to access this room after 11pm. The team leader reported that this would be accommodated, however had never occurred to her knowledge. The inspector also identified that the upstairs staff sleepover bedroom was an inner room. This will be addressed in Outcome 7.

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):

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

Findings:

The centre had satisfactory procedures in place for risk management and the prevention and control of infection. There were effective fire management systems in place and actions identified on the previous inspection were satisfactorily followed up. However, the inspector identified that an inner room was being used as a staff bedroom.

The team leader verbally outlined the identified risks in the centre to the inspector. There was a risk register in the centre, in addition to individualised risk assessments

relating to residents. The person in charge outlined the frequency and process by which these risks were reviewed. All risk assessments in the centre required sign off by the team leader or person in charge. The team leader also outlined residents' participation in risk assessments.

As had been identified in previous inspections, there was a risk in the centre regarding residents smoking. The team leader advised that there was a risk assessment in place for one of these residents. She outlined centre-wide controls in place regarding smoking and controls for the other residents who smoke that were not formally identified in a risk assessment. A notification had been submitted to HIQA regarding a fire in the staff office in the centre that resulted from charging an e-cigarette belonging to a resident. There was evidence of clear documented learning and revised practices following this incident.

In the centre access to the laundry was through the kitchen area. The team leader outlined the use of alginate bags and other infection prevention and control precautions taken in the centre regarding the washing of laundry, including those soiled with bodily fluids. There was documented evidence in the centre that a staff member from the Health Service Executive (HSE) had provided training on infection control procedures to staff working in the centre. One staff member was a trained hand hygiene assessor.

Suitable fire equipment was available in the centre. Records reviewed indicated that all pieces of equipment had been serviced in the previous twelve months by a competent person. The centre was also fitted with an alarm system and emergency lighting. Records reviewed indicated that these had been most recently reviewed in September 2017. The team leader advised that a staff member, with responsibility for health and safety in the centre, had identified that the quarterly service was overdue and had contacted the fire safety service earlier that week regarding this. The procedure for the safe evacuation of residents and staff in case of emergency was available in the centre. Each resident had a personalised emergency evacuation procedure (PEEP) reviewed within the last 12 months.

During the previous inspection, documentation was not available regarding fire drills in the centre. On this inspection records of fire drills were reviewed. 12 drills had taken place in 2017 and one in 2018. Of these 13 drills, at least one resident did not evacuate the centre on four occasions. This had been identified by management in the centre and actions were taken to address the issue. The two most recent drills had been successful, one of which involved all five residents, the other was in night time conditions. Future planning regarding fire drills was also outlined in the action plan that resulted from the six monthly unannounced visit to the centre in October 2017.

An action from the previous inspection also related to staff training in fire safety. Inspectors reviewed staff training records and identified that three out of 12 staff required fire safety training. These staff members were already booked into a training session to be held on 25 January 2018. The person in charge was able to show the inspector documentation confirming this. The previous inspection also identified delays in sourcing a fire apron for use in the centre. There were two aprons available for use in the centre on the day of inspection.

During inspection, it was identified that an inner room was being used as a staff bedroom. That is to say that the only escape route from the bedroom was through the staff office upstairs. As a result means of escape for the staff member may be impeded impacting on their own safety and that of residents who may require staff support. This inner room was not reflected in the floor plans submitted by the provider to HIQA.

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):

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

Findings:

Supports provided in the centre promoted a positive approach to residents' emotional needs. A restraint free environment was promoted in the centre. Measures to protect residents being harmed or suffering abuse were in place. However, as identified during the last inspection not all of the staff team had received the trainings outlined in the regulations.

It was reported to the inspector that none of the current residents engaged in behaviours that challenged. The team leader advised the inspector that a number of the residents were linked in with the local community health services and were supported to access these services, as needed. The inspector reviewed staff training records. During the previous inspection it was identified that two staff required training on how to respond to behaviour that is challenging, including de-escalation and intervention techniques, as is required by Regulation 7. During this inspection, the person in charge advised that four members of the 12 member staff team required this training. No dates had been confirmed. The team leader and person in charge demonstrated a good knowledge of restrictive practices. There were chemical restraints prescribed in the centre however these had not been administered. The team leader and person in charge were aware of the requirement to notify HIQA regarding any occasion when restraint was used. No environmental or physical restraints were evident in the centre. This was consistent with notifications submitted to HIQA by the person in charge.

There was a policy on, and procedures in place for, the prevention detection and response to alleged, suspected or confirmed abuse of residents. An action from the previous inspection related to four staff who required training in safeguarding residents and the prevention, detection and response to abuse, as per Regulation 8. On the day of inspection it was identified that one staff member of the 12 member staff team required this training. There were no recent concerns in the centre regarding alleged, suspected or confirmed abuse of residents.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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.

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:

The majority of actions identified under this outcome in the previous inspection were satisfactorily implemented. However, the provider did not have a clear, time bound plan to source an appropriate, alternative premises.

The inspector spoke with the team leader and person in charge regarding the current status of the provider's plan to source an alternative, more accessible property. Both advised that there was a meeting in late December 2017 with a housing body regarding a possible new build on an identified site. When asked if a collaboration had been confirmed or a timeline established, the inspector was advised that neither was confirmed and that another meeting was planned for January 2018. The person in charge confirmed that the lease on the current property was due to expire in May 2018. As such the action from the previous inspection regarding the failure to adequately progress the plan to secure alternative, safe and appropriate accommodation for residents remained outstanding.

It was outlined in the previous report that, due to other managerial commitments, it was not evident that the person in charge could ensure the effective governance, operational management and administration of the centre. A number of changes had occurred in the centre to satisfactorily address this finding. The inspector reviewed planned and actual

rotas for the centre. The person in charge informed the inspector that the current and future rota ensured that she was in the centre two, and often three, days a week. This was evident on the documented rotas and also confirmed by other staff in the centre when speaking with the inspector. The person in charge of the centre had the management experience as required by Regulation 14.

The inspector reviewed the reports generated following the two most recent six monthly visits to the centre by a representative of the provider. These were completed in May and October 2017. Both contained a plan to address any concerns identified. There was evidence in the centre of progress made regarding the majority of the items identified. The person in charge advised that the annual review for 2017 was not completed and provided the inspector with a copy of the 2016 edition. There was evidence in this review of consultation with the residents living in the centre.

At the last inspection there was no evidence of the implementation of performance management in the centre. The inspector reviewed a sample of staff files. From this review it was evident that once probation periods, and associated processes, were completed, staff had a documented meeting regarding their performance in the centre twice a year. In addition, each staff member attended supervision sessions at least four times a year. A completed and proposed schedule for these meetings was seen by the inspector.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

There were appropriate staff numbers and skill mix to meet the assessed needs of the residents and the safe delivery of services. There was a noted improvement in supervision practices in the centre. However, one staff member required refresher training in the safe administration of medication.

There were ten staff members regularly working in the centre. The centre had a relief panel comprising of two staff. The person in charge reported that agency staff were

very infrequently used, thereby ensuring a continuity of care and support for the residents living in the centre.

The inspector reviewed the actual and planned rotas in the centre. The last inspection report included an action in relation to staff supervision. As outlined in Outcome 14 the team leader or person in charge was in the centre 12 out of every 14 days. There were also planned and actual rotas available regarding staff supervision. The inspector reviewed a sample of staff supervision records and found a variety of appropriate topics were discussed.

During the previous inspection it was identified that not all staff had received appropriate training updates on moving and handling training. During this inspection, it was identified that four out of 12 staff required this training. However the person in charge reported that these staff were scheduled to attend training arranged for 1 February 2018 and could provide documentary evidence to support this. In addition, it was identified that one of the twelve staff required a refresher training in the safe administration of medication. Records indicated that this person did have up to date training in the administration of emergency medications prescribed to residents living in the centre. The person in charge assured the inspector that this person would be scheduled to attend a refresher training as a priority and would not administer medications in the centre in the interim. There was evidence of additional training provided to the staff team as a result of identified needs in the centre.

The inspector was informed that there were no volunteers working in the centre.

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:

Caitriona Twomey
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Peter Bradley Foundation Company Limited by Guarantee
Centre ID:	OSV-0001522
Date of Inspection:	10 January 2018
Date of response:	16 February 2018

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The premises did not meet the assessed 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:

The registered provider has endeavoured to ensure accessible accommodation for the assessed needs of residents. OT assessments have been completed and the outlined recommendations will be followed though in full as follows:

1. Full fire safety inspection of the whole premises by external body
2. Compliance with any/all recommendations arising from the inspection
3. Widening of front and back doors to increase accessibility
4. Widening of internal doors: kitchen, bedroom, bathroom and sitting room doors to increase accessibility.
5. Height adjustment to Aluminium ramp at front entrance
6. New Aluminium frame to be placed at back door entrances
7. Appropriate short ramp will be installed to allow full access to the smoking shelter

Proposed Timescale:

1. Friday Morning Feb 23rd
2. March 30th 2018
3. 31st May 2018
4. 30th April 2018
5. 30th March 2018
6. 30th March 2018
7. 30th March 2018

Proposed Timescale: 30/04/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

There was insufficient communal space in the centre.

2. 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:

1. Staff members on sleepover shifts will no longer use the downstairs sitting room to allow space be used for communal area.
2. A waking night will replace the second sleepover shift pending an assessment of need.
3. Removal of all items stored unnecessarily within the internal and communal spaces will be moved to external storage.
4. Archiving of information on file in the residence

Proposed Timescale:

1. 19th February 2018
2. 19th February 2018
3. 28th February 2018
4. 28th February 2018

Proposed Timescale: 28/02/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

There were inadequate means of escape for a staff member sleeping overnight, upstairs in the centre.

3. Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:

1. Staff sleepover area has been provisionally modified for accessibility and safety for evacuation through specified route.
2. Internal Door removed
3. Emergency lightening present in the room
4. Full fire safety inspection of the whole premises by external body
5. Compliance with any/all recommendations arising from the inspection

Proposed Timescale:

1. Date completed: Friday 19/01/18
2. Date completed: Friday 19/01/18
3. Date completed: Friday 19/01/18
4. Friday Morning Feb 23rd
5. March 30th 2018

Proposed Timescale: 30/03/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

From the records available on the day of inspection, four staff required training in how

to respond to behaviour that is challenging, including de-escalation and intervention techniques, as is required by Regulation 7.

4. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:

1. Issue communicated to HR Department
2. All relevant staff will be scheduled to receive MAPA Training

Proposed Timescale:

1. Training completed for all staff:30/03/18

Proposed Timescale: 30/03/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

From the records available on the day of inspection, one member of the staff team required training in safeguarding residents and the prevention, detection and response to abuse, as per Regulation 8.

5. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:

1. All relevant staff will be scheduled to receive Safeguarding Training.

Proposed Timescale: 29/01/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The managements systems in place had not adequately progressed the plan to secure alternative, safe and appropriate accommodation for the residents.

6. 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:

1. The registered provider will ensure stability of the lease for the residents for a three year period, to include review of lease with landlord and availability of signed lease.
2. Confirmation from Cork County Council for Joint project Tuath and Anvers housing to develop facility on Council land.
3. Building risk assessment by Housing Manager ABI Ireland
4. Implement recommendations made by Housing Manager
5. Feasibility study of site by Tuath Housing, in conjunction with ABI Ireland, and subsequent submission of the study to Cork County Council.
6. Finalisation and Submission of design and finance for new development by Tuath Housing to Cork County council (design finalisation in conjunction with ABI Ireland).
7. Submission of CAS or CALF application from Tuath Housing to Cork County Council
8. Release of site from Cork County Council to Tuath Housing
9. Secure construction team in line with relevant public procurement processes
10. Commencement of new build.
11. Completion of build.

1. Review of lease completed 25th January 2018; New Lease three year lease to 2021 agreed on 23rd February 2018
2. Confirmed by Cork County Council on January 24th 2018. Meeting Completed January 25th 2018
3. Housing Manager Review Complete 25/2/18
4. Implement any additional recommendation of Housing Manager not covered by other actions: 31/5/18
5. Date for completion: 31st of March 2018
6. Date for completion: 30th of April 2018
7. Date for completion: 30th of June 2018
8. Date for completion: 31st of December 2018
9. Date for completion: 31st of March 2019
10. Commencement of build: 31of May 2019
11. Completion of build: 30th of June 2020

Proposed Timescale: 30/06/2020

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

One staff member required refresher training in the safe administration of medication.

7. 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. All relevant staff will be scheduled to receive training in the safe administration of medication.

Proposed Timescale: 01/02/2018