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O'Gorman Home, Castle Street, Ballyragget, Kilkenny

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**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	O'Gorman Home
Centre ID:	OSV-0000547
Centre address:	Castle Street, Ballyragget, Kilkenny.
Telephone number:	056 883 3377
Email address:	anne58mcgrath@gmail.com
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	O'Gorman Home Committee
Provider Nominee:	Ann Brennan
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	3

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
- to carry out thematic inspections in respect of specific outcomes
- 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 wellbeing 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. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
19 July 2017 09:00	19 July 2017 17:00
20 July 2017 07:30	20 July 2017 15:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report sets out the findings of a two day unannounced inspection. This triggered inspection was conducted following receipt of unsolicited information of concern by the Health Information and Quality Authority (HIQA). These concerns were in relation to the administering of medication and specific infection control practices. The provider had submitted a provider led investigation to HIQA in relation to these concerns. However, following this inspection these concerns were not substantiated. In addition, the matters arising from the previous inspection of September 2016 were also followed up on this inspection.

O’Gorman Home is located in Ballyragget Co. Kilkenny. It is a voluntary centre, established in 1985 for the supported care of older people from the local and surrounding areas. The centre provides long-term and respite care for a maximum of 12 residents who require minimal assistance in a homely environment. On the days of inspection there were nine residents in the centre. All nine residents had been assessed as having low dependency needs. Funding for the service is by way of a grant and service level agreement with the Health Service Executive (HSE) under section 39 of the Health Act, 2004, voluntary fundraising, and residents’ own contributions.

This inspection was unannounced and took place over two days. All matters identified as needing to be addressed following the last inspection, had been attended to. As part of this inspection, the inspector met with residents, care staff, the staff nurse, the head carer and the person in charge. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The care provided to residents was of a good standard with an emphasis on providing a relaxed, homely and caring environment. Nursing and social care was in line with contemporary-based practices. Overall there was a respectful, supportive and social atmosphere in the centre. Residents had choices for example about the time they got up, what to get involved in and where to have their meals. The inspector noted that residents engaged in activities within the centre such as prayer services, cards, music and bingo and some also continued their attendance at other day services. Residents to whom the inspector spoke commented on the kindness and attentiveness of staff, the social interactions and opportunities and the good quality of the food provided. The centre had been a large period house and was homely in many aspects. For example, the dining room was located next to the kitchen and was attractively laid out which added to the homeliness and pleasantness of the dining experience. The sitting room was located across from this dining room, was carpeted and had the original fire place. Residents were very complimentary about the care, attention and support they received from staff. Residents stated that they felt safe in the centre and described the staff as "very caring".

There were seven outcomes reviewed as part of this inspection, five of the seven outcomes were compliant and one outcome substantially compliant with the regulations. However, the health and safety and risk management outcome was deemed to be moderately non-compliant. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

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

Findings:

The inspector found that there was a clearly defined management structure in the centre that outlined the lines of authority and accountability. The person in charge had operational responsibility for the centre, all staff including nursing and care staff reported to her and she in turn reported to the provider representative. The provider representative in turn reported to the governing board of directors who worked in a voluntary capacity. The provider representative was a member of the voluntary governing committee and supported the person in charge. The person in charge stated that the provider representative was in regular contact with her and met formally each month. Minutes of such meetings recorded issues such as risk management, quality improvements initiatives and operational challenges in relation to the management of the centre. These meetings were part of a quality management system that had commenced in the center in 2016. The provider, person in charge, the head carer and staff nurse met each month in a structured meeting to discuss for example any incidents accidents, complaints or audits in the centre. In addition, records were kept of corrective actions that had been identified and had been implemented. For example, there had been on going issues in relation to a number of the windows and patio doors in the centre. This issue had been identified at this meeting and progressed to the governing committee. Following this all windows and patio doors had been replaced in the center. Using the quality management system and structure, there were on going system of audit in place, capturing a number of areas, to review and monitor the quality and safety of care and the quality of life of residents. For example, there were audits in relation to medication management, safeguarding and safety, behaviours that challenge and care planning. There was evidence that resources were allocated to activities that promoted quality and safety and residents and relatives were very complimentary regarding same.

The person in charge, the head carer and the staff nurse displayed good knowledge of

the regulatory requirements. They were found to be committed to providing person-centred evidence-based health and social care for the residents. They were proactive in responding to the actions required from previous inspections and the inspector viewed a number of improvements throughout the centre including improvements in policy development, premises and care planning documentation.

There was evidence of good consultation with residents and relatives. Satisfaction surveys were carried out on a regular basis. Residents and relatives' questionnaires reflected a high level of satisfaction with care received in the centre. Policies have been updated and on-going training sessions were provided to staff on the roll out of the policies. There was an annual review for 2016 into the quality and safety of care delivered to residents that was available for residents.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge displayed a good knowledge of the standards and regulatory requirements and was found to be committed to providing quality person-centred care to the residents.

The inspector interacted with the person in charge throughout the inspection process over the two days. The inspector was satisfied that she was effectively engaged in the governance, operational management and administration of the centre on a day-to-day basis. She had a commitment to her own continued professional development and she had regularly attended relevant education and training sessions which was confirmed by training records. Staff and residents identified her as the person who had responsibility and accountability for the service and said she was approachable. It was clear that she always made herself available to them whenever they needed to discuss anything with her. She was employed to be in the centre 40 hours per week and she stated she did this by varying her hours to ensure she was in the centre at times other than 9am to 5pm. She was well known to the residents and staff and demonstrated sound knowledge of the residents needs.

Judgment:

Compliant

Outcome 07: 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 provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

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

Findings:

The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated a good understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. Safeguarding training was provided on an on-going basis in-house to all staff. Training records recorded that all staff had received up-to-date training all in a programme specific to protection of older persons. The person in charge stated that all staff recruited were given training in elder abuse as part of their induction. This was also confirmed by recently recruited staff. This training was supported by a policy document dated as reviewed in 2016 on elder abuse. This center specific policy defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise.

Residents had a high level of independence and the inspector was informed that residents or their representatives as appropriate, managed their own money. All residents were provided with a locked press to store their valuables in their bedrooms. Residents to whom the inspector spoke, confirmed that they did have great independence in all aspects of their lives including managing their own financial affairs.

There was a policy on behaviours that challenge. The person in charge reported that there were no residents in the centre who presented with behavior's that challenge. The person in charge confirmed that if required any resident with behavior's that challenge would be reviewed by their General Practitioner (GP) or other professionals for full review and follow up as required. Staff were provided with training in the centre on behavior's that challenge along with dementia specific training which was on-going. However, the training matrix indicated that most but not all staff had completed training in behavior's that challenge and this issue was actioned under outcome 18 of this report.

There was a policy on restraint which had been updated in July 2016. There was no forms of restraint including the use of bedrails used in the centre. All residents beds had been replaced in July 2016 and all had access to low - low beds, if required.

This was a small center with nine residents. The inspector noted that the atmosphere was homely, sociable and friendly. The inspector spoke to most of the residents over the two days and all stated that the staff were excellent and caring and that they felt very safe in their care.

Judgment:
Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

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

Findings:

Accidents and incidents were recorded on incident forms, were submitted to the person in charge and there was evidence of action in response to individual incidents. The inspector reviewed all notifications made to HIQA and cross referenced them against the recorded accidents in the centre. The inspector noted that suitable notifications had been made in relation to all accidents in the centre. There were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on corridors and safe walkways were seen in the outside areas.

The fire policies and procedures were centre-specific. There was a designated smoking area with a no smoking policy implemented inside the premise. The person in charge confirmed that one resident smoked in the center. The inspector noted that this resident had a smoking risk assessment and care plan in place. The fire safety plan was viewed by the inspector and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The inspector saw that fire training was most recently provided in February 2017 to staff and all staff had up to date fire training as required by legislation. The inspector was informed that further fire safety training was scheduled for this week. The person in charge told the inspector and records confirmed that fire drills were undertaken at a minimum each quarter in the centre. However, the record of the most recent fire evacuation drill completed in May 2017 was not adequate for the following reasons:

- the fire drill record did not detail the fire scenario that was simulated
- the fire drill record did not record any identified issues or problems encountered during the fire evacuation drill, therefore there was no record of any learning from the drill or improvements required as a result.

The inspector examined the fire safety register with detailed services and fire safety tests carried out. All fire door exits were unobstructed and fire fighting and safety

equipment had been tested in February 2017. Records viewed recorded that the fire alarm was last tested in June 2017 and the emergency lighting was last serviced in May 2017. Each resident had a personal emergency evacuation plan (PEEP's) in place.

The health and safety statement seen by the inspector was centre-specific and the health and safety policy was dated as being most recently reviewed in April 2017. There was a risk management policy as set out in schedule 5 of the regulations. The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. Clinical risk assessments were also undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. Accidents and incidents were recorded on incident forms and were submitted to the person in charge. There was evidence of action in response to individual incidents. However, risk management policy did not contain the specific measures and actions to control the specific risks of the following risks as required by regulation:

- abuse
- unexplained absence of a resident
- accidental injury to residents, visitors or staff
- aggression and violence
- self harm

The provider representative had contracts in place for the regular servicing of equipment and the inspector viewed records of equipment serviced which were up-to-date. There were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on most corridors and safe walkways were seen in the outdoor areas. However, there was no hand rail on the entrance corridor and this issue was actioned under outcome 12 of this report.

The communal areas and bedrooms were found to be clean and there was adequate standard of general hygiene at the centre. All hand-washing facilities had liquid soap. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. However, the training matrix indicated that most but not all staff had completed training in hand hygiene and infection prevention and control. This issue was actioned in outcome 18 of this report . In addition, there were a number of infection control issues including:

- there was one large opened container of medicated cream stored in a communal shower room without any residents' identifying details
- there were cobwebs in some of the ceilings and dust on an extractor fan
- cleaning practices as described by some staff were not in keeping with the centres' cleaning policy or with best evidenced based practice
- the use of cloth towels in each communal bathroom required review to ensure adherence to best practice in infection prevention and control practices.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

The centre-specific policies on medication management were dated as most recently reviewed in July 2016. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were comprehensive and evidence based. The policies were made available to nursing and care staff who demonstrated adequate knowledge of this document. Medicines for residents were supplied by a community pharmacy. Nursing and care staff with whom the inspector met outlined a robust procedure for the ordering and receipt of medicines in a timely fashion. Medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing and care staff. Medicines requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator and storage areas was noted to be within an acceptable range; the temperature was monitored and recorded daily.

Robust measures were in place for the handling and storage of controlled drugs that were accordance with current guidelines and legislation. However, there were no controlled drugs in the center at the time of inspection. Nursing and care staff with whom the inspector spoke demonstrated adequate knowledge of the general principles and responsibilities of medication management. Medicines were recorded as administered in the medication administration record in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais. Compliance aids were used by nursing and care staff to administer medicines. A sample of medication prescription records was reviewed.

There were no residents self-administering medication at the time of inspection. Medication administration was observed and the inspector found that the nursing and care staff adopted a person-centred approach. There was records of regular medication audits conducted including audits by the pharmacist which included on going consultations with residents.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are

drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

The dependency levels recorded in the centre were in keeping with the centres' statement of purpose. All nine residents had been assessed as having low dependency needs. There was a low reported incidence of healthcare issues. The inspector reviewed the management of clinical issues such as wound care and diabetes management and found they were well managed and guided by adequate policies. Residents to whom the inspector spoke were satisfied with the health and social service provided. Residents had access any General Practitioner's (GP's) of their choice. There were four visiting GP's currently attending the center and out-of-hours medical cover was provided. The person in charge outlined how the centre received a good level of ongoing support from visiting GP's. Some residents attended their GP independently and there were arrangements for suitable updates to be provided to the center, as appropriate. For example, a small number of residents attended their GP for regular blood coagulation (clotting) tests. There were records of the results of such tests recorded in residents' care plans. Any adjustments required to resident medication was also conveyed by residents' GP's to staff, as appropriate. Psychiatry of later life services were available and provided support to some residents. A range of other services was available on referral including speech and language therapy (SALT) and dietetics. Chiropody, dental and optical services were also provided. The inspector reviewed residents' records and found that where residents were referred to these services the results of appointments were recorded in the residents' notes. The inspector reviewed a sample of care plans and saw that they had been updated to reflect the recommendations of various members of the multidisciplinary team.

The inspector was satisfied that each resident's wellbeing and welfare was maintained by a good standard of care including appropriate medical and allied health care. The arrangements to meet each resident's assessed needs were set out in an individual care plan. Actions required from the previous inspection relating to care plans had been addressed and care plans were found to be person centred and generally reflected the care and social needs of residents. There was a documented assessment of activities of daily living, including mobility, nutrition, communication and sleep. There was evidence of a range of assessment tools being used to assess and monitor issues such as falls, pain management, mobilisation and risk of pressure ulcer development. Each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances.

For each resident there was a "My Day My Way" and "A Key To Me" document completed. These records were instrumental in developing staff knowledge and awareness into the background, preferences and social support needs of all residents.

Most but not all of these records were comprehensively completed in consultation with residents and/or their representatives, as appropriate. They were a rich resource of information to support residents, their representatives and staff in meeting residents social needs. The inspector noted that staff were knowledgeable of each resident's life history, hobbies and preferences which also informed the planning of residents' activities. From the sample of care plans reviewed, all were reviewed no less frequently than at four-monthly intervals. There was evidence that such reviews occurred in consultation with residents and/or their representatives.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. 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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

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

Findings:

Residents spoke very positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity at all times. The inspector observed positive interactions between staff and residents over the course of the inspection and found staff to have good knowledge of residents' needs as well as their likes and dislikes. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centered care to residents.

An actual and planned roster was maintained in the centre. The inspector reviewed staff rosters which showed that the person in charge was on duty Monday to Friday and there was also a head carer to support the person in charge in her role. Nurses were on duty 12 hours a week by day. The person in charge and staff confirmed that they were also available for staff to contact outside of hours, if required. The inspector observed staff practices and conducted interviews with a number of staff.

The person in charge informed the inspector that copies of the regulations and HIQA standards had been made available to all staff. From a review of minutes of staff meetings the inspector noted that a number of issues such as care standards, HIQA

inspections and notifications were discussed with staff.

From speaking to the person in charge, staff and a review of documentation; staff were supervised appropriate to their role and responsibilities. The inspector spoke with day and night duty staff who confirmed that they had been facilitated in accessing continuing professional education by the provider representative. There was an education and training programme available to staff. The training matrix indicated that mandatory training was provided and a number of staff had attended training in areas such as cardio pulmonary resuscitation (CPR). All staff had received elder abuse, manual handling and fire safety training. However, as outlined under outcome 8 the training matrix indicated that most but not all staff had completed training in hand hygiene and infection prevention and control and behavior's that challenge.

The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were seen by the inspector.

The provider representative confirmed that all staff and volunteers including those recently recruited, had the required vetting disclosure as required under the 2013 Regulations and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016.

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:

Vincent Kearns
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:	O'Gorman Home
Centre ID:	OSV-0000547
Date of inspection:	19 & 20/07/2017
Date of response:	11/08/2017

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

1. Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control

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

accidental injury to residents, visitors or staff.

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

Our risk management policy will include the measures and actions in place to control accidental injury to residents, visitors or staff as set out in Schedule 5

Proposed Timescale: 11/10/2017

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

2. Action Required:

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

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

Our risk management policy will include the measures and actions in place to control the unexplained absence of any resident as set out in Schedule 5

Proposed Timescale: 11/10/2017

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

3. Action Required:

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

Our risk management policy will include the measures and actions in place to control abuse as set out in Schedule 5

Proposed Timescale: 11/10/2017

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

4. Action Required:

Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

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

Our risk management policy will set out the measures and actions in place to control aggression and violence as set out in Schedule 5.

Proposed Timescale: 11/10/2017

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

5. Action Required:

Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

Our risk management policy will include the measures and actions in place to control self-harm as set out in Schedule 5.

Proposed Timescale: 11/10/2017

Theme:

Safe care and support

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

To ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff including the following identified infection control issues:

- there was one large opened container of medicated cream stored in a communal

shower room without any residents' identifying details

- there were cobwebs in some of the ceilings and dust on an extractor fan
- cleaning practices as described by some staff were not in keeping with the centres' cleaning policy or with best practice
- the use of cloth towels in each communal bathroom required review to ensure adherence to best practice in infection control practices.

6. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

All staff will refer to our cleaning policy for guidance to ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff including the following identified infection control issues:

ThT The PIC, and staff members, shall determine the cleaning schedule.

The use of cloth towels in communal bathrooms will be reviewed to ensure adherence to best practice in infection control practices.

Proposed Timescale: 11/11/2017

Theme:

Safe care and support

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

To ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire and that the fire drills include the following:

- the fire drill record did not detail the fire scenario that was simulated
- the fire drill record did not record any identified issues or problems encountered during the fire evacuation drill, therefore there was no record of any learning from the drill or improvements required as a result.

7. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

We will conduct fire drills at suitable intervals, to ensure that all staff and residents are aware of our procedure to be followed in the case of fire and we will use a new form to record the results which will include the following:

- the fire scenario that was simulated, the length of time taken for evacuation of residents as well as any problems or deficiencies identified during the drill.
- any identified issues or problems encountered during the fire evacuation drill, and these results will be brought to our Quality Management meeting so as to ensure we learn lessons from the outcome of our drill and also implement any improvements required as a result.

Proposed Timescale: 11/10/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Ensure that staff have access to appropriate training including training in hand hygiene and infection prevention and control and behavior's that challenge.

8. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

All staff has access to appropriate training including training in hand hygiene and infection prevention and control and behaviour's that challenge. Training in both topics will be updated so as to ensure that training includes all staff members. Due to financial constraints within the organisation it is often not possible to offer non mandatory training to staff immediately following recruitment. However the possibility of offering such training on an ongoing basis through a combined network group is currently being considered.

Proposed Timescale: 11/12/2017