

# eDeposit Ireland

## Carriglea, Laois

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Carriglea
<b>Centre ID:</b>	OSV-0003553
<b>Centre county:</b>	Laois
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	G.A.L.R.O. Limited
<b>Provider Nominee:</b>	Joe Sheahan
<b>Lead inspector:</b>	Declan Carey
<b>Support inspector(s):</b>	Ann-Marie O'Neill
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	4
<b>Number of vacancies on the date of inspection:</b>	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: 05 July 2017 10:00 To: 05 July 2017 19:30

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

The purpose of the inspection was to assess the centre’s compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

The previous inspection took place on 12th and 13th October 2015 and was to inform a registration decision. There were no actions from the previous inspection.

How we gathered our evidence:

Inspectors met with five staff members and interviewed three of them about the service being provided to residents. Inspectors spoke with the person in charge, deputy team leader and the area manager at length throughout the course of this inspection. Inspectors also had the opportunity to spend time and speak with two residents during the course of this inspection.

Policies and documents were also viewed as part of the process including a sample of the residents' health and social care plans, complaints policy, the contracts of care, health and safety documentation, safeguarding documentation and risk

assessments.

#### Description of the service:

The centre consisted of a large detached house that accommodated four residents with a range of individual support needs on a full time basis.

The provider G.A.L.R.O. (Guardian ad Litem and Rehabilitation Office) outlined the service supports residents to live full and valued lives in their community and at all times ensuring that stability, good health and well-being was achieved.

#### Overall Judgment of our Findings:

Inspectors found that arrangements were in place to provide residents with a caring and supportive environment. Staff and residents knew each other well and residents were observed to be at ease in the company of staff.

Of the outcomes assessed; social care needs, premises, risk management, safeguarding, medication management and workforce were found to be substantially compliant.

Healthcare needs and governance and management were found to be compliant.

These matters are further discussed in the main body of this report and in the action plan at the end.

**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 05: Social Care Needs**

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Overall the inspectors found that the social care needs of each resident was being supported and facilitated in the centre. Daily activities and social care goals were found to be meaningful. However, a comprehensive assessment of needs was not carried out annually for some residents.

The inspectors found that the care and support provided to the residents was to a good standard and from a sample of files viewed, each resident had comprehensive health, personal and social care plans in place. However, some residents' comprehensive assessments were in place but not carried out on an annual basis, as required by Regulations.

Inspectors observed that allied health professional assessments and recommendations in personal plans were up to date and were regularly reviewed. Should a need be identified for residents, a support plan was put in place for each need. For example, some residents had assessments from allied health professionals with recommendations made and supports plans were put in place to support residents.

Personal care plans were up to date and informative of each resident's likes, dislikes and interests and provided key information related to the resident to include, their meaningful day and important people in their lives.

The plans identified social goals that were important to each resident and from the sample viewed by the inspectors, it was observed that goals were being documented and a plan of action in place to support their achievement. Each residents' personal care plans were reviewed on a regular basis and discussed with residents with the

involvement of relatives or their representatives.

For example, some residents' social care goals included availing of local amenities, day trips, using visual aids for communication and furnishing their own personal space. The inspectors observed that some goals had been achieved or were in the process of being achieved at the time of this inspection.

Some residents also attended day services where they had the option to engage in activities such as exercise programmes, gardening, and computers. Some residents used assistive technology and computers in the designated centre.

Staff of the centre also supported residents to frequent local amenities such as shops, cinema, swimming pools and restaurants. Some events were held on the grounds of the designated centre and others were held outside of the designated centre where residents had the opportunity to meet with their peers.

**Judgment:**

Substantially 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):**

No actions were required from the previous inspection.

**Findings:**

This outcome was not inspected in its entirety as part of this inspection.

However, Inspectors found that two side gates required to be included in the refurbishment plan the provider had for the designated centre. Two side gates required to be repaired and one of these gates didn't provide privacy for residents engaging in activities in the back garden.

**Judgment:**

Substantially Compliant

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspectors were satisfied that the health and safety of residents, visitors and staff was promoted and protected and adequate systems were in place for the management of risk in the centre. However, this inspection found that there was not adequate measures in place to identify, assess and manage all risks in the designated centre.

There was a Health and Safety Statement in place which was specific to the centre.

There was also a policy on risk management for the designated centre. The risk management policy met the requirements of the Regulations. The centre also had a risk register which was made available to the inspectors on the day of inspection.

The inspectors were satisfied that, for the most part, where a risk was identified it was appropriately addressed and actions put in place to mitigate it. For example, there were assessments in place for the risk of epilepsy, missing persons, choking, and aggression. Measures were in place to mitigate these risks and found to be in place on the day of this inspection.

During the inspection, inspectors identified a risk that had not been managed in line with the designated centre's policies and procedures. Inspectors found that there was not adequate measures in place to identify, assess and manage a risk in relation to the volume of a medication held in the centre. A previous audit carried out by a pharmacist identified this risk, however this was not entered on the risk register. The person in charge outlined to inspectors this would be reviewed and entered in the risk register.

As in line with the risk assessment policy, all residents had a falls risk assessment in place. The inspectors found that any resident who was prone to falling had a comprehensive falls risk assessment in place that was regularly reviewed and updated.

There was also good evidence available that the centre responded to and learned from all adverse incidents occurring and there was a system in place to review all incidents and accidents. There were incident report forms completed for all incidents. The person in charge outlined risks for the centre and residents were reviewed on a monthly basis with management and discussed at staff meetings. For example, some residents rely on the use of visual boards and on one occasion the visual board was incomplete, which was identified in the review of an incident report form by the person in charge.

The inspectors also found that that a fire register had been compiled for the centre which was up to date. There was a fire safety officer in place in the designated centre. Fire equipment such as fire blankets and fire extinguishers were installed and had been checked by an independent company.

There was also emergency lighting, smoke detectors and fire doors installed in the designated centre.

Documentation read by the inspectors outlined that staff did checks on escape routes and fire alarm panel. Regular checks were also carried out by staff on fire equipment, manual call points, smoke detectors, emergency lighting and fire doors.

Fire drills were carried out quarterly and all residents had individual personal emergency evacuation plan in place. The inspectors also observed that there was an emergency response plan in place to provide support, guidance and procedures on what to do in the event of an adverse incident should it occur.

Inspectors reviewed a recent audit carried out on behalf of the provider that had identified the requirement for the installation of thumb locks on doors identified as emergency exits and the need for break glass panels for a quick exit in the event of a fire. Inspectors identified issues in relation to the requirement for a fire door in a utility room where the risk of fire was present. The inspectors brought this to the attention of the person in charge and the provider installed a fire door, required thumb locks on relevant exits and break glass panels prior to the end of this inspection.

There was also a recent fire safety report outlining that the fire system was in good working order, however an upgrade of the fire system was required. The provider outlined this would be addressed and identified a date for the upgrade of the fire system, prior to the end of the inspection.

There was also a missing person's policy in place for each resident, detailing relevant information. The aim of the policy was to ensure staff knew what steps to take should a resident go missing from the designated centre.

It was observed that there was adequate hand sanitizing gels, hand washing facilities and hot water available throughout the centre. It was found there were adequate arrangements were in place for the disposal of waste.

Of a sample of training needs viewed, all staff had the required training in fire safety. Most staff had required training in manual handling and this was discussed under Outcome 17, Workforce.

**Judgment:**

Substantially Compliant

**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*

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

The inspectors found that there were adequate arrangements in place to protect the residents from harm and abuse in the centre. However, an issue was identified in relation to intimate care planning for some residents.

There was a policy on and procedures in place for, safeguarding residents which staff had training on. Inspectors observed residents to be relaxed in the presence of staff on duty, on the day of inspection.

Staff spoken with during inspection, were able to demonstrate good knowledge on what constitutes abuse, how to manage an allegation of abuse and all corresponding reporting responsibilities and procedures. They were also able to identify who the designated person was in the centre and made reference to the safeguarding policies and procedures.

There was also a policy in place for the provision of personal intimate care and each resident had a personal intimate care plan on file. Some intimate care plans were informative on how best to support each resident while at the same time maintaining their dignity, privacy and respect.

However, inspectors found a lack of evidence with some intimate care plans on how to promote residents' independence with intimate care. For example, for some residents there was insufficient detail on what supports residents specifically require and did not require from staff.

There was a policy in place for the provision of positive behavioural support. This was to ensure a collaborative and integrative consistent approach in supporting individuals with behaviours of concern. Most staff were trained in the management of residents' assessed needs that included de-escalation and intervention techniques as required.

Staff spoken with by the inspectors, were able to verbalise their knowledge of residents' positive behavioural support plans. Staff knew how to manage residents' assessed needs in line with policy, standard operating procedures and each resident's positive behavioural support plan.

For example, included in positive behavioural support plans were guidelines for staff to identify when residents require support, proactive strategies, reactive strategies and residents' likes and dislikes. These issues were reviewed regularly with the input of staff from the centre, a behavioural support specialist, and a multidisciplinary team.

As required (p.r.n.) medicines were in use for some residents when other supports were not effective. Their use was documented in the positive behavioural support plans for residents. The use of p.r.n. medicines was reviewed regularly by a multidisciplinary team. Some p.r.n. medicines were in the process of being gradually reduced for some residents and this was monitored closely.

It was observed as required medicines were used only as a last resort and there were strict protocols in place for its use, which were adhered to. Inspectors were satisfied staff were knowledgeable of the protocols guiding the administration of p.r.n. medicines.

**Judgment:**

Substantially 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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found residents were being supported to achieve their best possible health and all healthcare needs were met.

Inspectors found that residents had access to a General Practitioner (GP) along with access to additional allied health care professionals such as occupational therapy, psychiatry, speech and language therapy, dietitian services and a dentist. Residents had access to a Behavioural Support Specialist and Psychologist on a regular basis, who worked with staff in the centre to support residents.

Inspectors found that residents were supported to attend appointments and follow-up appointments.

Information and advice from allied healthcare professionals was included and incorporated into residents' support plans. Inspectors reviewed a sample of support plans for specific health issues and found them to be concise, up-to-date and guiding good practice. For example, some residents had a detailed epilepsy management plan to support staff in providing care which included emergency support in and outside the centre. Other residents had specific care plans in relation to speech and language and this involved the multidisciplinary team, staff from the designated centre and an allied health professional, external to the centre.

Inspectors found the staff team were monitoring certain aspects of daily living to ensure

positive health and highlight any issues in a proactive way. For example, daily recording of food and fluid intake and weight monitoring.

Some residents assisted with making snacks and preparing meals at their own participation level. Inspectors found a varied diet was encouraged in the centre and residents had input into menu planning for breakfast, lunch and dinner. Some residents had a modified diet and staff were knowledgeable around the needs of residents who required extra support with meals. Meals were on display in the dining/kitchen area in photographic format so residents were aware of the menu plan.

**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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found safe practices in relation to the ordering, prescribing and administering of medicine in the designated centre. However, inspectors found practices in relation to the storage of medicines in the centre, required review.

There was a medicines management policy in place in the centre. The overall aim of the policy was to ensure safe and effective administration of medication in line with best practice. Inspectors observed medication audits were taking place on a weekly basis and any issues identified were addressed appropriately.

However, inspectors found the storage of medicines was not in line with the centre's medication management policy. The policy outlined all medication must be stored securely in a locked room in the staff office. Medicines were stored in an unlocked room within staff room which was locked. The person in charge outlined works for the installation of a keypad lock for the staff office and a keypad lock for the room where the medications were stored, was outstanding. The installation of keypads were previously identified in an audit carried out by the provider. The person in charge outlined this would be addressed as a matter of urgency.

There was a system in place to record any medication errors. The inspectors observed that if an error were to occur it would be reported accordingly to the person in charge and in line with policy and procedure. The inspectors observed that there had been no recent medication errors on record in the centre.

Staff outlined medicine was administered by the staff in the centre. Residents were assessed regarding their abilities to self-administer medicine, and inspectors found evidence all residents required assistance with safe administration of medication.

There were documentation systems in place for the records related to prescribed medication and their administration. For example, all residents had a prescription record with individual medicine signed off by the prescribing doctor and clear records were maintained regarding the administration of medicine by staff. Medicine was seen to be reviewed regularly by the prescribing doctor and the pharmacist.

The use of p.r.n (as required) medicine was monitored, with clear indication of the maximum dosage to be given in a 24 hour period. Emergency medicine for the response to epilepsy was carried with staff when supporting residents outside of the centre.

From viewing a sample of staff files it was observed staff were trained in the safe administration of medication.

**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):**

No actions were required from the previous inspection.

**Findings:**

Overall the inspectors found that there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the monitoring, provision and quality of the service delivered.

There was a clearly defined management structure in place which residents and staff were aware of. Front line staff reported to the person in charge, who reported to the area manager.

The centre was managed by a suitably qualified, skilled and experienced person in charge who was the team leader. From speaking with the person in charge at length

over the course of the inspection, it was evident that she had good knowledge of the individual needs and support requirements of each resident living in the centre.

The person in charge was aware of her statutory obligations and responsibilities with regard to the role of person in charge, the management of the centre and to her remit to the Health Act (2007) and Regulations.

The person in charge was also supported in their role by the area manager and deputy team leader who were also part of the management team in the centre. The inspectors met with the area manager and deputy team leader on day of the inspection and observed that they were also familiar with the centre and residents living there. In the absence of the person in charge, one of staff would assume the role of shift leader in the absence of the person in charge or deputy team leader .

There were a number of qualified social care workers and health care support workers on duty in the centre. There was a psychologist and behavioural support worker also on the roster for the centre. There was also an on call-system in place where staff could contact a manager, day or night in the event of any unforeseen circumstance.

An annual review of the safety and care provided in the centre was completed on behalf of the provider in November 2016. Two unannounced visits took place in the centre, as required by Regulations. Random internal audits were also carried out in the centre by the person in charge in the areas of key working, medication and health and safety. The inspectors viewed a sample of these audits and found areas of compliance and non compliance. Some issues identified were adequately addressed that brought about positive change for residents, for example audits identified the requirement for the replacement of electronic goods in the centre.

However, the inspectors reviewed a sample of audits that identified some outstanding actions required were not adequately addressed, with no details as to the person responsible or timeframe for the completion of some required actions. For example, there was an outstanding action in relation to the installation of an electronic keypad lock for a staff office and a room within the staff office containing medications, as discussed in Outcome 12.

Inspectors found the template of audits also required review, as audits were not effective in identifying some quality issues for some residents. For example, the comprehensive assessment was not carried out on an annual basis as required by Regulations for some residents, as discussed in Outcome 5. The template of audits did not review this issue and therefore was not identified on audits as a non-compliance. The area manager outlined to inspectors the system of audits conducted in the designated centre would be reviewed.

A sample of staff supervision records informed the inspectors that the person in charge was providing supervision, support and leadership to her staff team. The person in charge worked on a full time basis and was supernumerary to the roster. The person in charge was directly engaged in the governance, operational management and administration of the centre on a regular and consistent basis.

There were regular staff meetings organised by the person in charge involving all staff members in the designated centre. The person in charge was committed to their continuous professional development and engaged in all required staff training.

Throughout the course of the inspection the inspectors observed that all residents were familiar with the person in charge and appeared very comfortable in their presence.

**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):**

No actions were required from the previous inspection.

### **Findings:**

The inspectors found that there were sufficient staff numbers with the right skill-mix, qualifications and experience to meet the assessed needs of the residents. However, some gaps were identified in staff training and information required in Schedule 2 of the Regulations.

Inspectors reviewed a sample of staff files and found most staff were recruited, selected and vetted in accordance with best practice and Schedule 2 of the Regulations. Information and documents outlined in Schedule 2 of the regulations were missing for one member of staff. This member of staff did not have a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. The area manager outlined this member of staff would be re-assigned to other duties outside the designated centre, until the appropriate vetting had been completed.

The inspectors observed that residents received assistance in a dignified, timely and respectful manner. From observing staff in action it was evident that they were competent to deliver the complex care and supports needs required by residents.

The person in charge met with their staff team on a regular basis in order to support them in their roles. A sample of supervision notes were viewed by the inspectors. It was found that the supervision process was adequate and supported staff in improving their practice and to keep up to date with any changes happening in the centre.

From reviewing the training matrix for the designated centre, the inspectors observed gaps in training for some staff. Some staff required training in a number of areas including manual handling, food safety, autism and de-escalation and intervention techniques.

There was an actual and planned staff rota for the designated 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:***

Declan Carey  
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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by G.A.L.R.O. Limited
<b>Centre ID:</b>	OSV-0003553
<b>Date of Inspection:</b>	05 July 2017
<b>Date of response:</b>	03 August 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 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 05: Social Care Needs

**Theme:** Effective Services

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

Some residents' comprehensive assessments were not carried out on an annual basis, as required.

**1. Action Required:**

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

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

social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

We will review the assessment document and we will ensure that the assessment for each resident is reviewed and updated annually.

**Proposed Timescale:** 29/09/2017

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

Two side gates in the designated centre were in need of repair.

**2. Action Required:**

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

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

We will carry out necessary repairs to the two side gates at the designated centre. The sheeting in one gate will be repaired, while the second gate will be sheeted to ensure privacy of the residents.

**Proposed Timescale:** 11/07/2017

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

**Theme:** Effective Services

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

The systems in place for the ongoing review of risk relevant to the designated centre required review.

**3. Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

We have reviewed the risk management system to identify, assess and manage risk in relation to the volume of medication held at the centre and we will ensure that the volume of medication held at the centre is in accordance with recommendations from the pharmacist, and will be entered on the risk register.

**Proposed Timescale:** 07/07/2017

### **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:**

Some residents' intimate care plans did not contain sufficient information to promote residents' independence.

**4. Action Required:**

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

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

We will review intimate care plans for residents and we will provide step by step guidance for staff on the provision of intimate care for the residents. The plan will contain specific detail on what support is required from staff.

**Proposed Timescale:** 21/07/2017

### **Outcome 12. Medication Management**

**Theme:** Health and Development

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

The storage of medications in the designated centre, required review.

**5. Action Required:**

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

We have reviewed the storage of medication at the centre, we have installed a code entry lock to the staff office and a code entry lock to the storage room within the office. Each resident has individual medication storage cabinets which are also locked.

**Proposed Timescale:** 21/07/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

A vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for one member of staff, as specified in Schedule 2 of the Regulations was not present in a personnel file.

**6. Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

We have removed the staff member from the designated centre and transferred the staff member to the community office on administrative duties while we await receipt of Garda Vetting. Applied for Garda Vetting 06/07/2017.

Proposed Timescale: Expected date of Garda Vetting Notification 11/08/2017

**Proposed Timescale:** 11/08/2017

**Theme:** Responsive Workforce

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

From reviewing the training matrix in the designated centre, the inspectors observed gaps in training for some staff.

**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:**

We have reviewed the training matrix to ensure training needs specific to the designated centre are met. Training is arranged for staff who are due refresher training.

**Proposed Timescale:** 29/09/2017