ST. PATRICK'S CENTRE, KELLS ROAD, KILKENNY

Supporting People in Communities
St Patrick's Centre

Policy Document

POLICY TITLE:

Health Safety & Risk Management Policy

Prepared by:	Approval Date:	Review Date:
Anna-Maria Das Chaudhury Health & Safety Co-Coordinator	27/04/2016 10/09/2019 28/04/2020	27/04/2018 10/09/2021 28/04/2022
Policy Number 16 – Schedule 5	Approval By Signed: _____ CEO (Interim) Signed: _____ Board Member	

Mission Statement

To enable people to live a good life, in their own home, with supports and opportunities to become active, valued and inclusive members of their local communities.

To enable a supported self-directed living (SSDL) model of provision which is underpinned by our beliefs, values and vision.

Review Date:	Amendments Required	New Revision Status
_____28.04.2020___ Revision No:____4_____	COVID-19 pandemic included _____	Review date 28.04.2022 _____
Reviewed By: Annemarie Murphy Mirjam Lettner	Approved By: Signed:_____ CEO (Interim)	

Contents

1. Purpose of Policy

1.1 Health, Safety & Risk Management is the systematic process to positively identify, assess, treat and manage health, safety and risk. The purpose of this policy is to provide a framework for employees to identify, assess and rate health, safety and risks and to develop strategies in managing risk. This policy should be read in conjunction with:

- Complaints Policy
- Fire Safety Policy, PEEPs & CEEPs
- Behaviours that Challenge Policy
- Missing Persons Policy
- Health and Safety Statement Policy
- Accident/Incident Form and Pathway
- Risk Register
- Infection Control Policy
- Individual Risk Management Plans
- Personal Support Plans
- Guidance for Designated Centres-Risk Management (HIQA 2014)

2. Scope of Policy

2.1 The Policy applies to all employees of St. Patrick's Centre, Kilkenny (SPC) and is aligned to the HSE Integrated Risk Management Policy 2017. Health, Safety & Risk Management is not solely about managing risks. According to the World Health Organisation it is 'a means of identifying, assessing, prioritising and controlling risks across an organisation. A coordinated and cost-effective application of resources to reduce the impact of adverse events is required. Risk Management is a continuous process and has two key components i.e.

2.1.1 Proactive (preventative – uses information to prevent harm or loss).
SPC as a service provider is committed to being proactive in its approach to risk management. The people using the service are supported to live good and meaningful lives inclusive of risk as risk taking is an important part of a person's development. (Guidance for Designated Centres Risk Management, October 2014).

2.1.2 Responsive (reactive – action is taken following an adverse event, incident or near miss).
SPC is required by regulation and standards to have a Risk Management Policy and Procedure in place which includes the identification, assessment, management and ongoing review of risks through the organisation at two levels: -

2.1.2.1 A Corporate Level: which relate to risks to SPC, such as risks to its financial viability, reputation or risk associated with change and transition, risks to employees and visitors i.e. SPC Corporate Risk Register.

2.1.2.2 An Individual Level: which are risks that directly affect the person using the service? These risks are managed in Individual Risk Assessments. Individual Risk Assessments shall be developed in a person centred approach involving the person supported, their family/representative and employees.

2.2 This policy is designed to ensure:

2.2.1 That Health, Safety & Risk Management principles are integrated into all aspects of service delivery.
2.2.2 That employees are informed and knowledgeable about positive risk management through training and development.
2.2.3 That all hazards/risks are identified and managed proactively.
2.2.4 That all accidents, incidents, complaints and near misses are effectively managed.
2.2.5 That all notifiable incidents are reported to the relevant authority on time and in line with protocol (i.e. An Garda Siochana, HIQA, HSE, TUSLA, NIMS/State Claims Agency, HSA and SPC Board of Management).
2.2.6 That transparent processes and good practice are in place.
2.2.7 That management decisions are supported.
2.2.8 That accountability is improved.
2.2.9 That quality and efficiency is increased.
2.2.10 That there is immediate risk prioritisation.
2.2.11 That positive attitudes are instilled in implementing risk controls.
2.2.12 That people supported are enabled to maximise their autonomy to realise their will and preference within a person centred ethos.

2.3 This policy has been reviewed in light of the outbreak of the global COVID-19 pandemic. St. Patrick's Centre (Kilkenny) (SPC) acknowledges that during events like a global pandemic all operational and therapeutic supports need to be risk assessed as outlined in this Risk Management Policy to ensure a safe service for all people supported.

In order to ensure a safe service and consistent with HSE advices, SPC is availing of support from Infection Prevention and Control Hub for designated centres in HIQA. The aim of the HIQA Infection Prevention and Control Hub is to provide a direct line of contact for providers and staff of social care services to offer guidance and support during the COVID-19 pandemic around infection control issues.
The HIQA Infection Prevention and Control Hub services will provide support and guidance on:

- outbreak preparedness
- outbreak management advice to include:
  - resident placement
  - cohorting and special measures in centres where isolation is not possible
  - staff cohorting in the management of suspected and infected cases
  - transmission-based precautions
  - standard precautions.

The SPC Emergency and Continuity Plan will guide the service during the COVID-19 pandemic. Risk assessments and Standard Operating procedures are being developed and made available to all staff members to ensure the adherence to all guidance and procedures.

3. Definitions:

3.1 Risk: Organisational:

Risk can be defined at "the chance of something happening that will have an impact on the achievement of organisational stated objectives" (HSE 2008) or "the effect of uncertainty on objectives" (ISO 31000: 2009).
Risk: Individual

Risk is 'a means of identifying, assessing, prioritising and controlling risks across an organisation, with a coordinated and cost-effective application of resources to minimise, monitor and control the probability and/or impact of adverse events or to maximize the realisation of opportunities'
World Health Organisation.

3.2 Risk Management:
The culture, processes and structures that are directed towards, realising potential opportunities whilst managing adverse effects. 'It is important to be aware that not every situation or activity entails a risk that needs to be assed or manged. The risk may be minimal and no greater for the person who uses the service than it would be for someone who is not using a service'. (Guidance for Designated Centres Risk Management')

3.3 Integrated Risk Management:
A continuous, proactive and systematic process to understand, manage and communicate risk from an organisation-wide perspective. It is about contributing to strategic decision making in the achievement of an organisation's overall corporate objectives.

3.4 Risk Management Process:
The systematic application of management policies, procedures and practices to the task of communicating, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk.

3.5 Risk Assessment:
The overall process of risk identification, risk analysis and risk evaluation.

3.6 Risk Register:
A risk register is a database of risks that face an organisation at any one time. Always changing to reflect the dynamic nature of risk and the organisation's management of them, its purpose is to help managers prioritise available resources to minimise risk and target improvements to best effect.

3.7 Monitor:
To check, supervise, observe critically or measure the progress of an activity, action or system on a regular basis in order to identify change from the performance level required or expected.

3.8 Safety:
The state of being safe, the condition of being protected against physical, social, spiritual, financial, political, emotional, occupational, psychological or other types or consequences of failure, damage, error, accidents, harm or any other event which could be considered not desirable.

3.9 Quality:
Doing the right thing consistently to ensure the best outcomes for service users, satisfaction for all people supported, retention of employees and facilitation of excellent financial performance.

4. Responsibilities

4.1 The Service Provider (SPC)

4.1.1 Risk Management responsibility rests with SPC who has overall responsibility for ensuring that procedures and processes are in place to enable adherence to this Policy.

4.1.2 Under the Health Act 2007 (CARE AND SUPPORT OF RESIDENTS IN DESIGNATED CENTRES FOR PERSONS (CHILDREN AND ADULTS) WITH DISABILITIES) REGULATIONS 2013, SPC must ensure the following risk management procedures are in place:

4.1.2.1 Hazard identification and assessment of risks throughout each department and house is assessed, acted upon and review dates set to reduce the risk within each service area.

4.1.2.2 Measures and actions to control the risks identified, where additional resources are required, SPC must make the required resources available to the relevant personnel.

4.1.2.3 Measures and actions to control the following specified risks:

- the unexpected absence of any resident
- accidental injury to residents, visitors or staff,
- aggression and violence, and
- self-harm;

4.1.2.4 Arrangements for the identification, recording and investigation of, and learning from serious incidents or adverse events involving people supported are in place and followed through.

4.1.2.5 Arrangements to ensure that risk control measures are proportional to the risk identified and that consideration is given to any adverse impact that such measures might have on the quality of life of the people we support.

4.1.2 SPC will ensure that there are systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

4.1.3 SPC will ensure there is provision of adequate training and awareness of Health, Safety & Risk Management.

4.1.4 SPC will ensure the Corporate Risk Register is maintained including reviews and same is provided to HSE per Service Agreement.

4.2 Management

4.2.1 Anyone in a position of leadership is responsible for the following in relation to Risk Management:

4.2.2 That they and all their employees within their responsibility are familiar with the contents of the Risk Management Policy and are working to adhere to this policy to proactively manage risk.

4.2.3 To complete Individual Risk Assessments, identification of appropriate controls and supporting the implementation of these controls.

4.2.4 Ensure that all policies, procedures, protocols and guidelines designed to manage risks are implemented as appropriate.

4.2.5 They identify, assess and manage risk using a balanced approach within their area of control. This should identify what is and what is not an acceptable risk.

4.2.6 Ensure that all hazards are managed proactively i.e. development of risk assessments, safety statements and risk registers for their department and/or house in co-operation with line managers.

4.2.7 Ensure that all incidents/complaints/near misses are reported, effectively managed, including action, review, monitoring, learning and escalation.

4.2.8 The identification of new risks that cannot be managed locally are forwarded to the Health & Safety Department.

4.2.9 It is the responsibility of all CSMs, PICs and Team Leaders to ensure that all staff are familiar with house specific emergency response procedures.

4.3 Employees

4.3.1 All direct support employees are responsible for the following in relation to Risk Management.

4.3.2 It is the responsibility of all employees to be familiar with this policy.

4.3.3 Report any hazards, near misses and incidents not in compliance with this policy.

4.3.4 All employees are responsible for the identification of risks in their area of work and involvement in individual Risk Assessment activities and effective reporting on variations that may impact on the risk management outcomes.

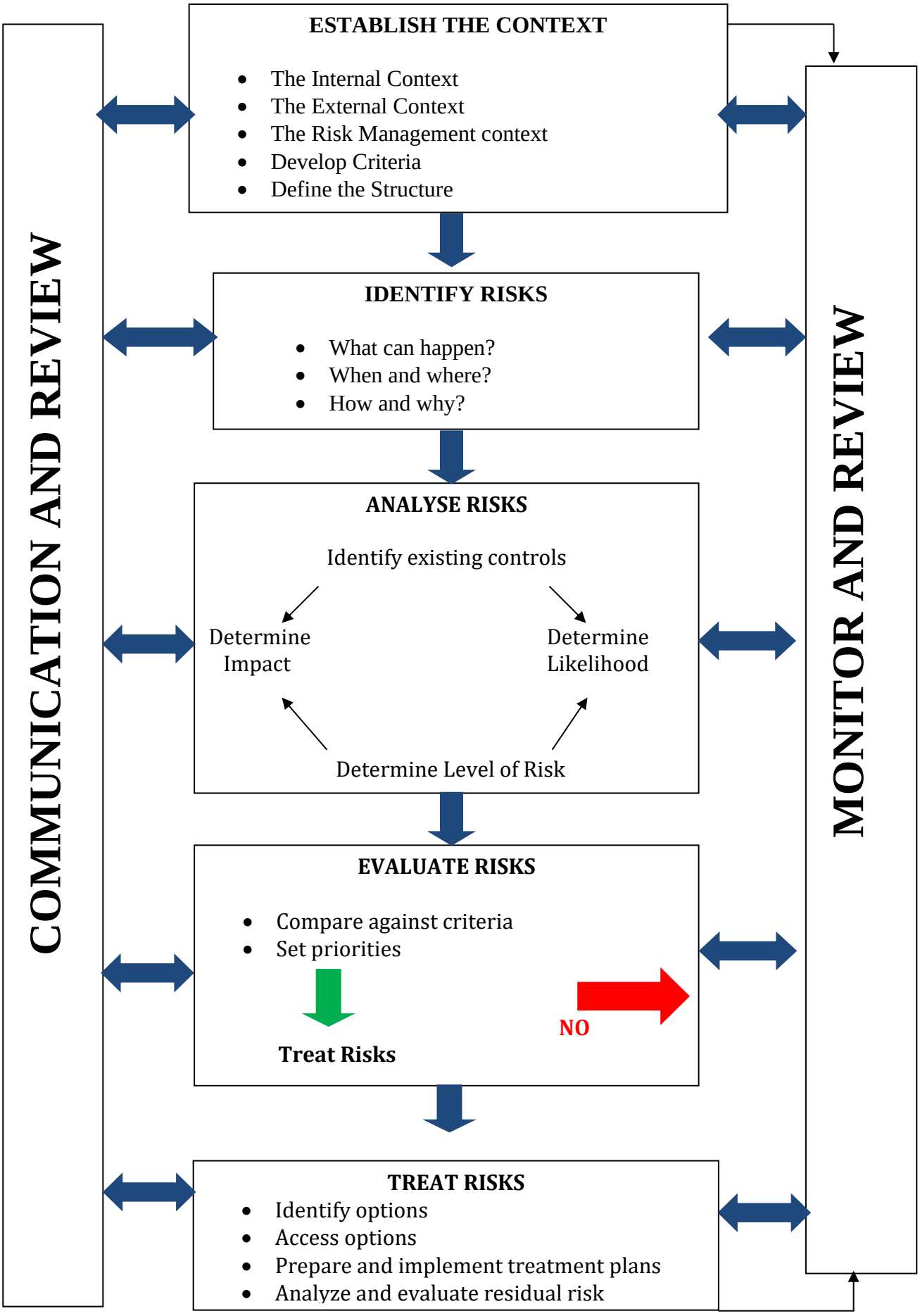
5. Hazard Identification and Categories of Risk

5.1 Risk/Hazards can be categorised as: clinical, public liability and employee liability. The following are the risk areas identified:-

5.1.1 Risk of injury to People supported/Employees and the Public
5.1.2 Professional Standards Risks
5.1.3 Objectives and Project Risks
5.1.4 Business Continuity Risks
5.1.5 Financial Risks
5.1.6 Reputational Risks
5.1.7 Environmental Risks and
5.1.8 Audit/Inspection/Accreditation/Standards/Legislative Risks

5.2 Appendix 1 *'SPC Risk Management Plan*' contains a list of categories of risk. This is not an exhaustive list and can be added to as required.

6. Risk Register Development Process



6.1 Risk Management comprises of the following activities:

6.1.1 Communicate and Consult:
Communicate and Consult with relevant internal and external stakeholders as appropriate at each stage of the risk management process.

6.1.2 Establish the Context:
Establish the external, internal and risk management context in which the rest of the process will take place incorporating The Health Act 2004 & 2007, the need to improve the safety of the persons supported and to learn from reported accidents and complaints.

6.1.3 Identify the Risks:
Identify where, when, why and how events could prevent, degrade, delay or enhance the SPC objectives. Approaches used to identify risk include:-

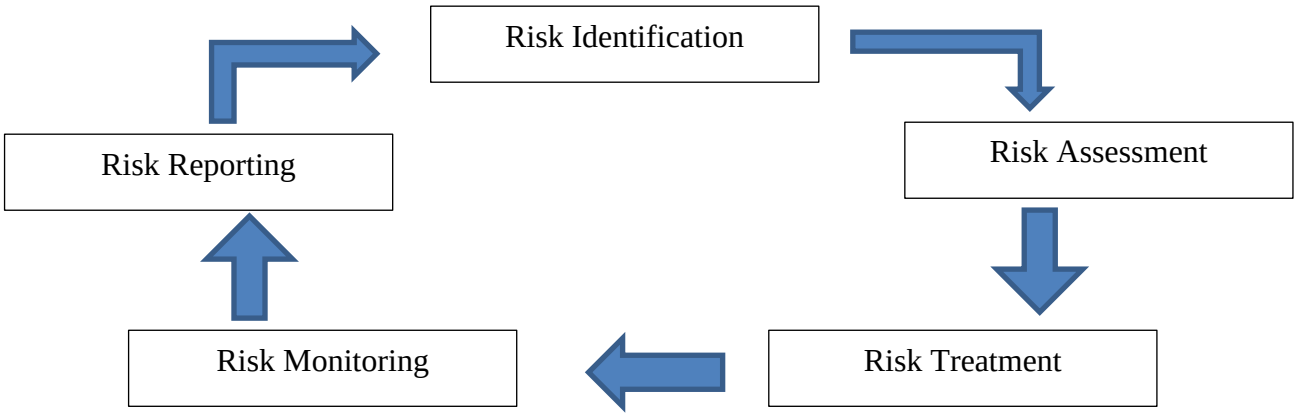
6.1.3.1 Employee training
6.1.3.2 Incidents
6.1.3.3 Complaints
6.1.3.4 Think Tank Sessions
6.1.3.5 Judgement based on experience and records
6.1.3.6 Systems Analysis
6.1.3.7 Scenario Analysis

6.1.4 SPC has adopted the ICC Approach: (Impact, Cause and Context).

6.1.4.1 Impact – describe the potential impact if the risk were to materialise
6.1.4.2 Cause – describe the causal factor that could result if the risk materialised.
6.1.4.3 Context – ensure that the context of the risk is clear.

SEE RISK RATING TABLE (Appendix 2)

6.2 The Risk Management Cycle



6.3 Analyse the Risks - each identified risk should be analysed in terms of:

6.3.1 The existing controls in place to manage the risk

6.3.2 Likelihood of an incident occurring
6.3.3 Impact to determine the level of risk posed

6.4 The impact and likelihood should be assessed using the Risk Assessment Matrix. In analysing risk it is important to consider not only the issue of minimising risk but also maximising opportunity. The resultant analysis should be documented in the risk register.

6.5 Evaluate the Risks:
The purpose of risk evaluation is to make decisions, based on the outcomes of risk analysis, about which risks need treatment and the treatment priorities. This requires comparing estimated levels of risk against the pre-established criteria and then to consider the balance between potential benefits and adverse outcomes for the service. This enables decisions to be made about the extent and nature of the treatments required and the priorities for the department/designated centre.

6.6 Treat the Risks:
Where risks require further treatment (action) and a treatment (action) plan is developed to address it. This plan should outline the specific cost effective actions to be taken, the person responsibility and the timeframe for action. The plan should aim to reduce the level of risk. If possible risks should be eliminated. Where this is not possible, the risk should be reduced to as low a level as is reasonably practical.

6.7 Monitor and Review:
It is necessary to monitor and review the effectiveness of all steps of the risk management process. For each stage of the process records should be kept to enable evidenced based decisions to be documented as part of the process of continual improvement and learning.

7. Specific Risk Management Procedures

7.1 Identification, Assessment and Control of Risks
Risk Management processes must be in line with HSE "Guidelines for Risk Assessment". Risk must be rated according to the Risk Matrix.

OVERVIEW OF SPC RISK MANAGEMENT PROCESS	
STEP 1	**Hazard Identification & development of Risk Register for each designated centre. Once a hazard is identified, the risk of injury or illness needs to be established by completing a Risk Assessment which will quantify the hazard which in turn indicates its significance and the attention level the hazard deserves.**
STEP 2	**Any employee of SPC can carry out a Risk Assessment. This may be prompted by the observation of a risk, or a perceived risk, as identified in Step 1 above. It can follow information received from a person supported, family member**

	or member of the public. **Discuss the risk identified with the PIC/Team Leader and complete the risk assessment form.**
STEP 3	**Depending on the seriousness of the risk identified and the control measures and/or resources that need to be put in place to address the risk, the Risk Assessment may be discussed with the Community Service Manager for advice and direction.**
STEP 4	**A review date will be set.**

7.3 SPC Risk Management Process

7.3.1 All risks identified during the process of developing the risk register must have a 'Risk Assessment' conducted in conjunction with the person supported, employee and management of the individual department and / or houses. **Appendix 3** ***'Risk Assessment Form'.***

7.3.2 Risk assessments carried out for a person supported must be filed in the person's personal plan, risk assessments carried out pertaining to the environment, and / or generic items must be filed in the department / house Risk Register folder.

7.3.3 All Risk Assessments must be signed by the PIC/Team Leader and employee team for the particular area.

7.3.4 Action plans within the risk assessment that cannot be managed at local level must be referred to the appropriate senior manager or department within SPC in order for decisions to be taken to manage the risk identified. (i.e. it may require additional resources).

7.3.5 The completed risk assessment must be brought to the attention of all staff working in the area in a clear manner taking account of the level of training, knowledge and experience by the CSM and/or PIC/Team Leader.

7.3.6 Review dates must be recorded and strictly adhered to.

7.4 Updating Risk Assessments / Registers

7.4.1 All risk assessments to be reviewed by the PIC/Team Leader and employee in each house/department as indicated on the risk assessment form but at least yearly.

7.4.2 The relevant person i.e. PIC/Team Leader or employee will complete the Additional Controls (Actions) Update form (**see Appendix 3**)

7.4.3 The relevant person i.e. PIC/Team Leader or employee will then attach the updated form to the appropriate risk assessment form; this will reduce the need to carry out a full risk assessment when not required.

7.4.4 This process should be repeated regularly as indicated on the risk assessment but at least yearly.

7.5 Re-assessment of Existing Risks

7.5.1 It is good practice to review the risk assessment annually or when required taking account of any new controls that have been put in place since the original assessment. This will allow re-prioritisation of the risk list thereby focusing the efforts of the service to address those risks that are most pertinent to the service.

7.5.2 When re-assessing existing risks, the PIC/Team Leader/CSM should compare the risk rating from the re-assessment with the risk rating of the original assessment. If the reduction of risk levels is not as anticipated in the original assessment, then the PIC/Team Leader/CSM will need to check why i.e. have the additional controls been effectively implemented? If they have why are they not reducing the rating? Are they the right controls and if not is there a need to revisit and enhance the control measures?

8. The Identification, Recording and Investigation of, and Learning from, Serious Incidents or Adverse Events Involving Residents

8.1 Following a serious incident or adverse event the appropriate Person in Charge / Team Leader/ CSM will convene a meeting with all employees, multi – disciplinary team, health and safety committee and management within 72 hours to debrief staff, review incident and agree action plan.

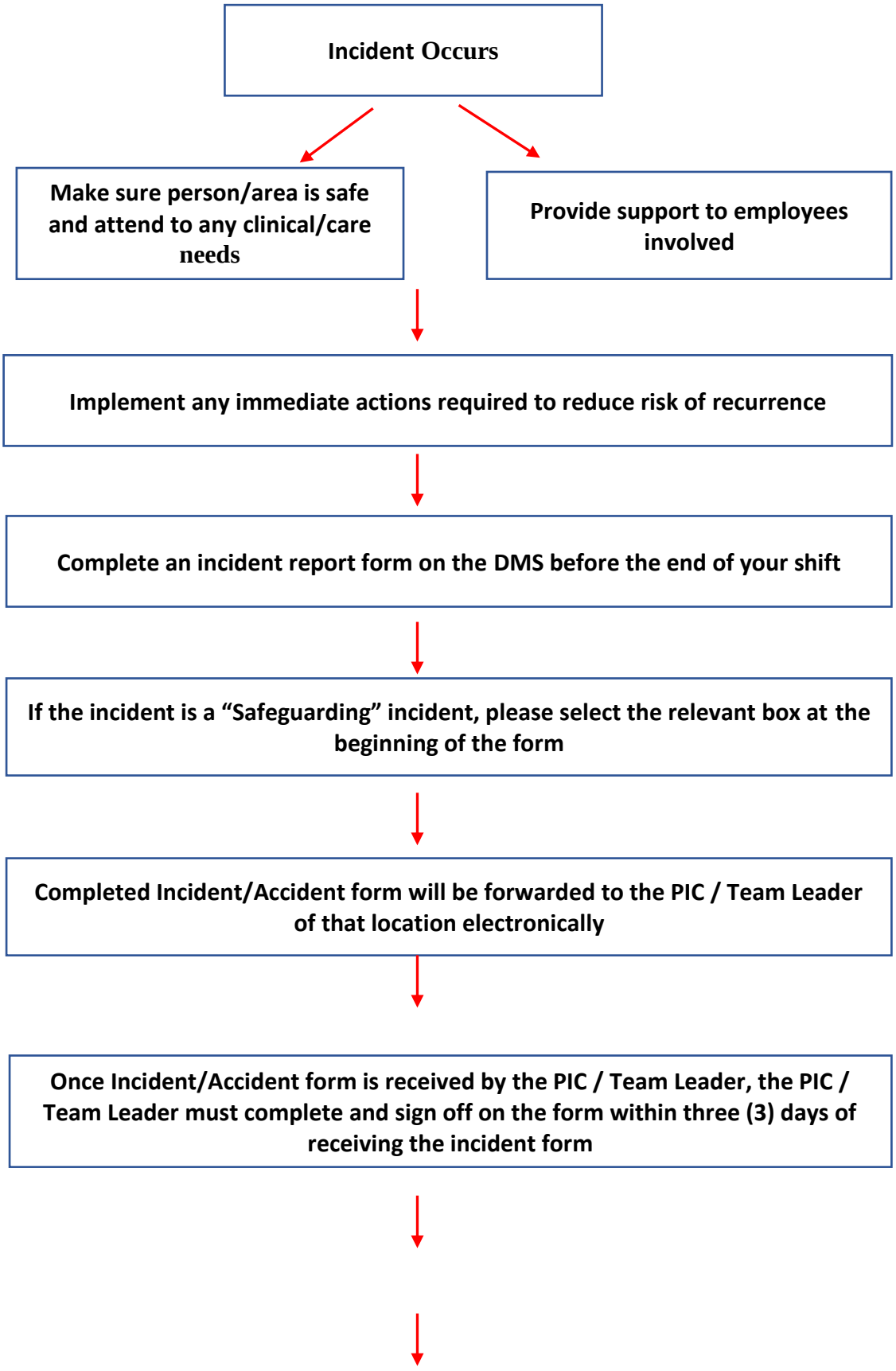
8.2 Action Plan will be implemented by appropriate staff.

8.3 The Person in Charge / Team Leader/Community Service Manager will inform HIQA as required within the specified time frames as set out by the Health Information & Quality Authority.

8.4 Review of the incident to be conducted by the SMT within ten days to ascertain learning from the incident, implement appropriate actions and inform all staff, service users of actions across service.

8.5 Relevant PIC/Team Leader/CSM to convene a review within three months or sooner if deemed necessary with all staff involved to determine if action plan has reduced and / or eliminated the risk of a reoccurrence of incident

9. SPC Incident/Accident Pathway



If deemed necessary the PIC / Team Leader can alert the following disciplines of the incident

- **Behavioural Support Specialist**
- **Clinical Supervision Specialist**
- **Director of Services**
- **Health and Safety Dept.**
- **HR Dept.**
- **Medication Manager**
- **Operations Manager**
- **Quality Office**
- **Social Worker Dept.**

Once Incident/Accident form is received by the CSM, the CSM must complete and sign off on the form within three (3) days of receiving the incident form

Once an Incident/Accident form has been actioned by the PIC / Team Leader & CSM, it will be marked as CLOSED, at this stage the incident form can be printed if required

Closed incidents are viewable under the "Person Supported" tab on the DMS

The PIC / Team Leader may convene a meeting with all staff, multi – disciplinary team and health and safety Dept. within 72 hours of incident if deemed to be a serious incident to debrief staff, review incident and determine action plan

The PIC / Team Leader will inform HIQA as required within the specified time frames as set out by the Health Information & Quality Authority.

Review of a major incident to be conducted by senior management team within ten days to ascertain learning from incident, implement appropriated actions and inform all staff and person supported of actions across service.

10. Communication of Health Safety & Risk Management Policy, Health & Safety Statement, Risk Management Register & Individual Risk Assessments.

10.1 The Health Safety & Risk Management Policy, Health & Safety Statement, Risk Management Register & Individual Risk Assessments shall be: -

10.1.1 Communicated to all employees, including temporary employees in a language that is easy to understand.

10.1.2 Brought to the attention of all employees, including temporary employees, on an annual basis at a minimum and following any amendments.

10.1.3 Communicated to all newly recruited employees, including temporary employees upon commencement of their employment.

10.1.4 Communicated to any other persons who may be exposed to any specific risks identified within the risk management documentation. This may include any contracted service provider.

10.1.5 Communicated to the people supported by the service and their representatives.

10.2 Open Disclosure

11. Open Disclosure

SPC & HSE Open Disclosure Policy 2019 require that in the event of an adverse event (accident or incident*): -

1. We communicate with the people we support in an open, honest, transparent and empathic manner following an accident or incident*
2. We provide the people we support with a sincere and meaningful apology when they are harmed as a result of an accident or incident and
3. We begin the communication process within 24 to 48 hours of the accident or incident occurring or become known to SPC or as soon as possible after the accident/incident

There are three types of incidents under the HSE Open Disclosure Policy 2019 as follows:-

- Harm or suspected harm
- No harm
- Near miss

We must disclose all *harm* and *suspected harm* incidents. We must generally disclose *no harm* incidents. Assess *near miss* incidents on a case by case basis. We must inform the people we support

of a *near miss* or *no harm event* if there is potential for it to become a harm event in the future.

For further details on the principles of Open Disclosure, protection under the Civil Liabilities Bill 2017 and the process for following Open Disclosure, please see the HSE Open Disclosure Policy 2019.

12. References

- Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013
- HSE Integrated Risk Management Policy 2017
- HIQA Guidance on Risk Management

Appendix 1 RISK MANAGEMENT PLAN

Regulatory Requirements	**Current Control Measures – Strategies to reduce / manage Risk and what residual risk is left.**
1. The unexpected absence of any resident	Potential for unscheduled absence of resident, policy on Missing Persons and protocols to be used when resident is missing.
2. Accidental injury to residents, visitors or staff	Good Housekeeping, presence of First Aider, Occupational First Aider, First Aid Box, referral to Dr. & A&E, Back up arrangements.
3. Aggression and violence/assault by other people using the service.	Presence of Challenging behavior, Behaviour support plan, Back up procedures, Environmental conditions, Violence at Work, training in Behaviour Support Management (Studio 3)
4. Self-harm	History of self-harm, intensity level, aetiology of self-harm. Medication. Ongoing risk assessments, sufficient control measures will be implemented, recorded in Service Users Support Plan. Training provided to relevant staff.
Potential Hazard Sources	**Current Control Measures – Strategies to reduce / manage Risk and what residual risk is lift.**
5. Electricity	All Electrical installations are tested and certified by a competent electrician. All Portable Appliances to be tested by a competent electrician (PAT).
6. Fire	Fire training provided for staff and people using services. Extinguishers in house, checked and serviced annually. Monthly fire drills conducted and collated. PEEP's in place for Individual Service Users. CEEP's in place for Centre Evacuation & Egress and Evacuation procedures posted in house.
7. Slips, Trips and Falls	Safety Checklist utilized on a daily basis covering both Day and Night shift
8. Manual Handling and Patient Lifting	Training provided on current manual handling procedures – staff trained every 2 years as required. Safe techniques employed at all times.
9. Cleaning	Checked in daily routine and standard hygiene procedures adhered to. Hygiene audits to be conducted quarterly.
10. Hot objects	Objects which present with burn/scald are protected from sensitive individuals. Guarding of Radiators etc.

11. Sharp objects	Hazard Audit regularly check for sharp edges, sharps procedure and accidental inoculation procedures to be adhered to.
12. Access to drug/medicine	Medication training provided to staff. Administration of Medication Policy & Procedure, Medication recording, medication audits.
13. Microwave/Oven/Range	Regular cleaning carried out, visual observations carried out daily. PAT Testing annually by competent Electrician.
14. General Equipment	Specialist Equipment identified with maintenance schedule. Ensure adequate equipment infection controls.
15. Challenging Behaviour	Challenging Behaviour training provided. Behaviour plans for individuals, responding to Challenging Behaviour in Adult Services.
16. Good Health	Annual Health Check – General Health Provision, daily checks on individuals, Epilepsy Management Plans. Ensure appropriate personal support plans and effective health support (including adequate review of quality and safety of support). Ensure sufficient communication (including sufficient provision of information to Service Users regarding treatments)
17. Protection from Abuse & Neglect	Policy on Management of Allegations of Abuse. The welfare and protection of vulnerable adults – national procedures, the investigation of allegations. Training of all staff. All staff are qualified, trained and vetted. Where abuse is suspected Our Lady's shall follow a standardized process to determine if abuse occurred and take appropriate action including disciplinary action) dependent on the outcome. All Service Users, including their families/representatives and staff shall be encouraged to report and suspected abuse.
18. Stress	Company Doctor and Counsellor available to all staff. Currently sourcing further Employee Assistance Programme.
19. Managing Assets - Organisation	Petty cash return system, Internal controls, external audits
20. Managing Assets – Residents	Finance Policy for good practice in the handling of the personal assets of people who use the services. Audits to be put in place annually.
21. Food	Food Hygiene, Nutrition, Meal Planning. Is there provision of information, training, supervision and monitoring of staff re food safety.
22. Household Activities	Social outings and holidays, daily activity schedules
23. Sudden Death	End of Life Policy

24. Staff Training	Suitable Qualified Staff, Adequate Skill Mix, a training needs analysis has been completed and all staff are up to date with training. Vulnerable adults, Manual Handling, report writing, First Aid, fire training, Medication Training, epilepsy training, Risk Management, Staff Supervision.
25. Use of Volunteers	This Service uses Volunteers, they are complementary to Staff, they undergo the same screening process as Staff, and they are supervised on an ongoing basis.
26. Reporting Structures	All staff are aware of their local and wider Service area, communications are done by face to face meetings, telephone calls and reports. All significant reports are recorded in writing. An on call system is in place and this is sent to House on a monthly basis. All staff are aware of the time thresholds for HIQA reporting.
27. General Maintenance	All Staff are aware that good housekeeping is adhered to, if any item requires repair or maintenance that is outside the scope of staff present then the Maintenance Procedure is followed
28. Complaints	There is a Complaints procedure in place for all residents, Staff will respectfully receive and record all complaints and forward them to the relevant personnel, who in turn will examine the complaint and rectify anything necessary. All complaints to be recorded on the complaint Log
29. Compliance with HIQA Regulations and Standards	Ongoing continuous and unrelenting adherence to all the requirements of HIQA.
30. Statement of Purpose	There is a folder of current Policies and Procedures in the house and all staff have read and understood them. All staff have signed to this effect.
31. Policies and Procedures	There is a folder of current Policies and Procedures in the house and all staff have read and understood them. All staff have signed to this effect.
32. Individual Assessment	All individuals have assessment and personal plans pertinent to their needs and they have been involved in these assessments. These are recorded and on their files.

33. Rights/Restrictive Procedures	All residents and staff rights are upheld. An annual assessment is completed and actions may be required from these. Occasionally rights restrictions may be imposed for safety and therapeutic reasons, but these are reviewed on a three monthly basis or more often. All rights restrictions are referred to our human rights committee. Service User will undergo an individual assessment and any decision making regarding restraint shall be made with the involvement of the Service User. A written record of any occasion on which physical or chemical restraint is used, the nature of the restraint and its duration shall be retained.
34. Communication	Communication is an essential ingredient to ensure the effective running of a service. We have staff rosters posted on a monthly basis, ensure good handover, activity planning and recording, other activities recording.
35. Intimate Care	Intimate Care Policy in place.
36. Disposal of Waste	What types of waste do we produce, how is it disposed of, do we have sharps, and is waste contaminated with body fluids?
37. Infection Control	What infection measures do we have in place, are people we support in a more vulnerable group. Do we use shared towels, how do people know their own towel. Do we have adequate laundry controls and sufficient hand hygiene. Is there adequate management of communicable diseases? Safe specimen handling, Legionella Controls, policies on sharps and Needle stick injuries and adequate cleaning and waste management policies.
38. Visitors	Visitors are always welcome to the houses. Prior knowledge is advisable and the protection of residents is paramount. See Visitor Policy.
39. Directory of Residents	A directory of residents is kept up to date.
40. Management	The management of the house is maintained by planning, organizing and controlling the effective use of resources to meet the needs of the residents. Is there Standards of Procedure in place i.e. Risk management, incident reporting, emergency planning, quality assurance, effective insurance cover, appropriate accounting and finance management, supplier and contractor controls and appropriate

	Statement of Purpose.
41. Supervision	What is the level of supervision of staff required to ensure that they are supported to implement the support required by the people using services in the house. Resources are always scarce, therefore how does it fit in with "Industry Norms"
42. Medication Management	What policies do we have in place regarding administration of medications, management of controlled drugs, self-administration, complementary therapies and over the counter medications. Is there adequate management of prescribing, ordering, storage and disposal of medications? Are there controls regarding crushing of medications?
43. Facilities	Is the premises fit for purpose i.e. Appropriate for use. Is there adequate security, access/egress? Is there adequate sanitary, toilets and washing facilities? Is there sufficient communal space, outdoor are controls? Space? Vehicle Movements?
44. PPE Personal Protective Equipment	SPC will provide and maintain suitable PPE for use by staff. PPE shall be used to reduce the risk of infection within SPC.

Appendix 2 RISK RATING TABLE (RISK MATRIX)

What would the impact of this risk be on the organisation if it were to occur

1. IMPACT TABLE	Negligible 1	Minor 2	Moderate 3	Major 4	Extreme 5
Injury	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required < 3 days absence < 3 days extended hospital stay Emotional Distress	Significant injury requiring medical treatment e.g. Fracture and/or counselling. Agency reportable, e.g. HSA, Gardai (violent and aggressive acts). > 3 Days absence 3-8 Days extended hospital stay Emotional Trauma	Major injuries/term incapacity or disability (loss of limb) requiring medical treatment and/or counselling Physical/emotional disability	Incident leading to death or major permanent incapacity. Event which impacts on large number of patients or member of the public (Emotional/Physical trauma)
Service User Experience Satisfaction	Reduced to quality of service user experience related to inadequate provision of information	Unsatisfactory service user experience related to less than optimal support and/or inadequate information, not being to talked to & treated as an equal; or not treated with honesty, dignity & respect – readily resolvable.	Unsatisfactory service user experience related to less than optimal support/service resulting in short term effects (less than 1week)	Unsatisfactory service user experience related to poor support/service resulting in long term effects	Totally unsatisfactory service user outcome resulting in long term effects, or extremely poor experience of care provision
Legal / Regulatory Compliance with Standards Policy/Procedure/ Structures	Minor non compliance with internal standards. Small number of minor issues requiring improvement	Single failure to meet internal standards or follow protocol. Minor recommendations which can be easily addressed by local management	Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Failure to meet national norms and standards/Regulations (e.g. Mental Health, Child Care Act etc) Critical report or substantial number of significant findings and/or lack of adherence to regulations	Gross failure to meet external standards. Repeated failure to meet national norms and standards / regulations. Severely critical report with possible major reputational or financial implications.
Objective/Projects Operational Plan	Barely noticeable reduction in scope, quality or schedule	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule	Significant project over – run.	Inability to meet project objectives. Reputation of the organisation seriously damaged.
Business Continuity / Service Delivery	Interruption in a service which does not impact on the delivery of /ability to continue to provide service.	Short term disruption to supports/service with minor impact on service users.	Some disruption in service with unacceptable impact on service users. Temporary loss of ability to provide supports/service	Sustained loss of service which has serious impact on delivery of supports/service resulting in major contingency plans being involved.	Permanent loss of core supports and services. Disruption to supports/services leading to significant 'knock on' effect.
Publicity/ Reputation / Media	Rumours, no media coverage. No public concerns voiced. Little effect on staff morale. No review/investigation necessary.	Local media coverage – short term. Some public concern. Minor effect on staff morale/public attitudes/ Internal review necessary.	Local media – adverse publicity. Significant effect on staff morale & public perception of the organisation. Public calls (at local levels) for specific remedial actions. Comprehensive review/investigation necessary.	National media/adverse publicity, less than 3 days. News stories & features in national papers. Local media – long term adverse publicity. Public confidence in the organisation undermined. Use of resources questioned. Public calls (at national level) for specific remedial actions to be taken possible HSE review/investigation.	National/International media/adverse publicity, > than 3 days. Public confidence in the organisation undermined. use of resources questioned, Performance questioned, calls for individual's to be sanctioned. Public calls (at national level) for specific remedial actions to be taken. Court action. Public (Independent) Inquiry.
Financial Loss (per Local Contact)	<€1k	€1k - €10k	€10 - €100k	€100k - €1m	>1m
Environment	Nuisance Release	On site release contained by organisation	On site release contained by organisation	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc)	Toxic release affecting off-site with detrimental effect requiring outside assistance.

2. LIKELIHOOD SCORING

What is the likelihood of this risk occurring in the next year given the current vulnerabilities and controls

Rare/Remote -1		Unlikely -2		Possible -3		Likely -4		Almost Certain 5)	
Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability
Occurs every 5 years or more	1%	Occurs every 2-5 years	10%	Occurs every 1-2 years	50%	Bimonthly	75%	At Least monthly	99%

3. RISK MATRIX	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

Appendix 3 RISK ASSESSMENT FORM St. Patrick's Centre (Kilkenny)

Date of Assessment & Planning Meeting:			
Person Supported:		**D.O.B.**	
House:			
Meeting attended by:	**Name:**	**Role:**	
What is the Risk:			

Risk Description	**Impact/Vulnerabilities**	**Existing Controls Measures**	**Additional Controls Measures**	**Person's Responsible for Action**	**Review Date**
		•			

Initial Risk			**Remaining Risk (To its Lowest Possible Level)**			
Likelihood	**Impact**	**Initial Risk Rating**	**Likelihood**	**Impact**	**Remaining Risk Rating**	**Status (Green/Amber/Red)**

Additional Controls (Actions) Review Sheet

Number	Additional Controls	Additional Control (Action) Summary Update	Person Responsible for Action (If Changed)	Action Status Behind schedule/On Schedule/Complete Schedule	Next Review Date

Please sign and date the below confirming that you have read and fully understand the contents of the above mentioned "Risk Assessment"

Signed By: **Date:** **Signed By:** **Date:**

ACTION: ***If additional control measures are completed, please review & update a new Risk Assessment Form.***