DEPARTMENT OF HEALTH

FACILITY FOR SEVERELY/PROFOUNDLY INTELLECTUALLY DISABLED CLIENTS SCHEDULED INSPECTION

DAY CARE ☐ **RESIDENTIAL CARE** ☐
tick one or both, as applicable

1. FACILITY INFORMATION

NAME:

_____

ADDRESS:

PHYSICAL	POSTAL
PHONE NO:	FAX NO:
e-mail:	

CENTRE MANAGER: _____

NURSING OFFICER IN CHARGE: _____

CONTROLLING BODY: _____

DATE OF INSPECTION: _____

INSPECTION CONDUCTED BY:

_____

_____

_____

2. ORGANISATIONAL INFORMATION

COPY OF CONSTITUTION SEEN	YES	NO
CONSTITUTION LAST UPDATED (date)		
DATE OF LAST AGM		
NEXT AGM DUE DATE		
LATEST AUDITED FINANCIAL STATEMENTS PROVIDED TO GHD	YES	NO
IS ORGANISATION FUNDED BY ANY OTHER GOVERNMENT DEPT?	YES	NO

COMMENT *(e.g. if no constitution/audited statements, funding from other depts)*

COMPOSITION OF CONTROLLING BODY (EXECUTIVE COMMITTEE)

CATEGORY	NUMBER
PARENTS	
PROFESSIONALS (EXCL STAFF)	
STAFF	
COMMUNITY	
OTHER	

MEETINGS OF CONTROLLING BODY: FREQUENCY _____
check minutes

ATTENDANCE | GOOD | FAIR | POOR |

COMMUNITY INVOLVEMENT: IS THERE ANY? WHAT IS ITS NATURE?

ORGANISATIONS LICENSED PRIOR TO 1994 ONLY

EXTENT OF TRANSFORMATION | SATISFACTORY | FAIR | POOR |

NATURE OF TRANSFORMATION EFFORTS, OBSTACLES, PROGRESS

3. LICENCE AND SUBSIDIES

CURRENT LICENCE SEEN | YES | NO | VALID FROM _____ TO _____

IF NOT SEEN, WHY NOT?

_____

NUMBERS	ON LICENCE	CURRENT CLIENTS*	SUBSIDIES ALLOCATED	SUBSIDIES PAID	ELIGIBLE CLIENTS NOT RECEIVING SUBSIDY
DAY					
RESIDENTIAL					

** see below, Client statistics, Occupied Totals for Day care and Residential care*

REASONS WHY ELIGIBLE CLIENTS ARE NOT RECEIVING SUBSIDY _____

_____

_____

4. CLIENT STATISTICS

BREAKDOWN OF PLACES *(Occupied = number on register)*

	PLACES	ADULTS 18+		CHILDREN 3 - 17		BABIES 0 - 2		TOTALS
		M	F	M	F	M	F	
DAY CARE	OCCUPIED							
	VACANT							
	TOTAL							

	PLACES	ADULTS 18+		CHILDREN 3 - 17		BABIES 0 - 2		TOTALS
		M	F	M	F	M	F	
RESIDENTIAL CARE	OCCUPIED							
	VACANT							
	TOTAL							

PERCENTAGE OF CLIENTS FROM FORMERLY DISADVANTAGED GROUPS: _____

Residential care only

HOW MANY RESIDENTS HAVE FAMILY CONTACT?

WEEKLY	MONTHLY	YEARLY	NEVER

WHAT EFFORTS ARE MADE TO FACILITATE/MAINTAIN FAMILY CONTACT?

_____

_____

_____

5. PERSONNEL

DIRECT CARE-GIVING, SUPERVISORY & SUPPORT STAFF

If day and residential facility, with staff working in both settings, record only once, in primary work setting

DESIGNATION	DAY CARE		RESIDENTIAL	
NURSING STAFF	**FILLED**	**VACANT**	**FILLED**	**VACANT**
NURSE MANAGERS				
SENIOR PROFESSIONAL NURSES				
PROFESSIONAL NURSES				
SENIOR ENROLLED NURSES				
ENROLLED NURSES				
SENIOR ENROLLED NURSING AUXILLIARIES				
ENROLLED NURSING AUXILLIARIES				
CAREWORKERS/VOLUNTEERS				
TRAINED CARE WORKERS				
CAREWORKERS IN TRAINING				
UNTRAINED CAREWORKERS			4.	
VOLUNTEER CAREWORKERS				
HOUSEHOLD STAFF				
HOUSE KEEPING			2.	
KITCHEN			0	
ADMINISTRATIVE			1	
MAINTENANCE			I	
SECURITY			1	
DRIVER/S			1	
GARDENER/S			1	
CLEANERS / DOMESTIC WORKERS			1	
OTHER (SPECIFY)				

RATIO OF STAFF TO CLIENTS

	DAY		RESIDENTIAL	
	STAFF	CLIENTS	STAFF	CLIENTS
REGISTERED STAFF				
ENROLLED STAFF				
AUXILIARY STAFF				
CAREWORKERS				

ARE THESE RATIOS ADEQUATE FOR SAFE CARE? YES | NO

IF NO, WHAT ARE THE MINIMUM STAFFING REQUIREMENTS FOR (a) SAFETY (b) BASIC STIMULATION PROGRAMME & BY WHEN MUST THE ADDITIONAL STAFFING BE PROVIDED?

MULTIDISCIPLINARY TEAM	STATE	OWN/VOL	FREQUENCY	
			HRS/DAY	DAYS/WK
MEDICAL OFFICER/S				
PSYCHIATRIST/S				
PSYCHOLOGIST/S				
SOCIAL WORKER/S				
SOCIAL WORK ASSISTANT/S				
OCCUPATIONAL THERAPIST/S				
OCCUP. THER ASSISTANT/S				
PHYSIOTHERAPIST/S				
PHYSIO ASSISTANT/S				
SPEECH THERAPIST/S				
TEACHERS				
PODIATRISTS				
OTHER THERAPISTS (specify)				

IF ANY OF THE MDT IS NOT AVAILABLE TO SEE CLIENTS AT THE CENTRE, ARE THERE ARRANGEMENTS FOR REFERRAL/CONSULTATION IF NECESSARY, AND, IF SO, WHERE?

IS THERE A NEED TO IMPROVE ACCESS FOR CLIENTS TO ANY OF MDT? YES | NO

IF YES, WHAT IS BEING/ CAN BE DONE TO IMPROVE THE SITUATION?

DO ALL FULL TIME STAFF HAVE:		YES		NO	
ON/OFF DUTY ROSTERS					
JOB DESCIPTION					
DUTY SHEETS					
REGULAR PERSONAL EVALUATIONS:	Not done	1/12	3/12	6/12	12/12
HOW OFTEN ARE THESE DONE?		✓			

S.A.N.C. RECEIPTS *if nurses are employed*

ARE RECEIPTS CHECKED AND COPIES KEPT BY NURSING MANAGER?	YES | NO
WERE THESE SEEN DURING THE INSPECTION?	YES | NO

IF NO TO EITHER, EXPLAIN:

6. STAFF DEVELOPMENT

IN-SERVICE TRAINING: PROGRAMME & ATTENDANCE RECORDS SEEN? | YES | NO |

PERSON(S) RESPONSIBLE: _____

_____

CATEGORY OF STAFF	FREQUENCY	TOPICS SINCE LAST INSPECTION

OTHER FORMS OF TRAINING ATTENDED SINCE LAST INSPECTION

TITLE	FORMAT	ATTENDED BY

HOW IS FEEDBACK GIVEN FOLLOWING ATTENDANCE?

_____

_____

TRAINING OF CARE WORKERS	YES	NO
TRAINING PROGRAMME AND ATTENDANCE RECORDS SEEN?		
IS THERE AN APPROPRIATE CURRICULUM?		
IS AN EVALUATION DONE?		

COMMENTS: _____

_____

_____

_____

7. STAFF ATTITUDES

Comment on:

ATTITUDES/UNDERSTANDING OF STAFF RE WORK WITH THESE CLIENTS:
How do they view the clients? How do they understand concepts of stimulation/rehabilitation?

RELATIONSHIPS BETWEEN MANAGEMENT AND STAFF:

ATTITUDE OF STAFF/MANAGEMENT TO RECOMMENDATIONS FOR IMPROVING THE SERVICE:

8. ADMINISTRATION OF CARE

ARE THE FOLLOWING MANUALS PRESENT IN EACH WARD/UNIT?
** Required only if nurses are employed*

	COMPLETE	INCOMPLETE	WHEN UPDATED	NIL
POLICY				
PROCEDURE (see below)				
LEGISLATION:				
HEALTH ACT				
MENTAL HEALTH ACT				
* NURSING ACT				
REGULATIONS:				
* ACTS & OMISSIONS				
* SCOPE OF PRACTICE				

COMMENTS ON MANUALS AND PROCEDURES *(see next page)*:

ARE THE FOLLOWING PROCEDURES PRESENT IN THE MANUAL OF EACH WARD/UNIT

** Required for residential care only*

	PROCEDURE FOR :	YES	NO
	ADMISSIONS		
	ANNUAL PHYSICAL AND MENTAL ASSESSMENT OF CLIENTS		
*	BATHING OF CLIENTS		
	CARE OF CLIENT'S PROPERTY		
	CARE TO BE TAKEN WITH REGARD TO HIV INFECTION		
	CHANGING OF SOILED CLIENTS		
*	COLLECTING OF SPECIMENS		
	DAILY PROGRAMMES		
	DISCHARGE PREPARATION PROGRAMMES		
	DISCHARGES		
	EXERCISING OF CLIENTS		
	FAMILY INTERVIEWS		
	FEEDING OF CLIENTS NOT ABLE TO DO SO		
	INJURIES TO CLIENTS		
	KEEPING OF RECORDS		
	MANAGEMENT OF AGGRESSIVE CLIENTS		
	MANAGEMENT OF SELF MUTILATING CLIENTS		
	MEDICATION : ADMINISTRATION		
	MEDICATION : CONTROL		
*	NURSING ROUNDS/MEETINGS		
*	OBSERVATION FOR EFFECTS / SIDE EFFECTS		
*	OBSERVATIONS : TAKING OF TPR AND BP		
	CLIENT ABUSE: PREVENTION, INVESTIGATION OF ALLEGATIONS		
	CLIENT DEATH		
	CLIENT OUTINGS		
	CLIENT ILLNESS		
	CLIENT SEXUAL RELATIONSHIPS		
*	PRESSURE PART CARE		
	REFERRALS TO DOCTOR/PSYCHIATRIST		
	REFERRALS TO OT		
	REFERRALS TO PSYSIOTHERAPIST		
	REFERRALS TO SOCIAL WORKER		
	WRITING OF REPORTS		
	OTHER:		

MEDICATION *Residential care only*	YES	NO
ARE ALL SUBSTANCES:		
IN LOCKED CUPBOARDS?		
IN A DRY, COOL PLACE?		
STILL SUITABLE FOR USE (EXPIRY DATES CHECKED)?		
CLEARLY LABELLED?		
ARE SUBSTANCES FOR EXTERNAL & INTERNAL USE KEPT SEPARATE?		
IS CORRECT PROCEDURE FOR TELEPHONIC ORDERS CARRIED OUT?		

EMERGENCY EQUIPMENT	YES	NO
IS THERE A PROPERLY EQUIPPED FIRST-AID BOX/KIT?		
ARE THE CONTENTS REGULARLY CHECKED FOR SUITABILITY FOR USE?		
ARE STAFF TRAINED TO USE FIRST AID?		
Following required for residential care only		
IS OXYGEN AVAILABLE?		
IS OXYGEN CHECKED DAILY TO ENSURE: SUFFICIENT		
IN WORKING ORDER		
IS SUCTION APPARATUS AVAILABLE?		
IS IT CHECKED DAILY TO ENSURE WORKING ORDER?		
IS AN EMERGENCY TROLLEY/CUPBOARD AVAILABLE?		
IS THE LIST OF CONTENTS AVAILABLE?		
DOES IT CONTAIN ALL THE NECESSARY REQUISITES?		
ARE THE CONTAINERS SEALED?		
ARE THE ITEMS CHECKED FOR: EXPIRY DATES?		
REPLACEMENT AFTER USE?		
ARE DRUGS FOR PHYSICAL EMERGENCIES AVAILABLE?		
ARE DRUGS FOR PSYCHIATRIC EMERGENCIES AVAILABLE?		
ARE THE CHECK LISTS SIGNED & DATED?		

COMMENTS ON MEDICATION AND EMERGENCY EQUIPMENT:

RECORD KEEPING

* *Required for residential care only*	YES	NO
ARE RECORDS KEPT SECURELY?		
IS ALL ADMISSION/DISCHARGE INFORMATION PROPERLY RECORDED?		
ARE FOLLOWING OBSERVATIONS ROUTINELY RECORDED?		
PHYSICAL HEALTH		
SEIZURES		
GROSS/FINE MOTOR CO-ORDINATION		
COMMUNICATION		
SELF-HELP SKILLS		
EMOTIONAL STATE		
* TEMP, PULSE, RESP.		
* BLOOD PRESSURE		
* INTAKE & OUTPUT		
* BOWEL ACTIONS		
* BLOOD SPECIMEN RESULTS		
ARE RESULTS OF ANNUAL MENTAL/PHYSICAL ASSESSMENTS RECORDED?		
ARE RESULTS OF SPECIAL INVESTIGATIONS/ASSESSMENTS FILED/RECORDED?		
ARE TREATMENT/MANAGEMENT RECOMMENDATIONS RECORDED?		
ARE ALL ASPECTS OF CLIENT MANAGEMENT FULLY RECORDED?		
ARE THERE RECORDS OF COMMUNICATION WITH THE FAMILY?		

Random sample of records should be checked – do not rely on report only

COMMENTS ON METHOD AND FREQUENCY OF CLIENT RECORD KEEPING:

9. CARE OF CLIENTS

OBSERVATIONS ON CLIENT STATUS *(Brief comments on each- if necessary, write overleaf)*

PHYSICAL ASPECTS

NOURISHMENT _____

CLEANLINESS _____

PRESSURE SORES _____

OPEN WOUNDS _____

RESPIRATORY INFECTIONS _____

CLOTHING *(condition, appropriateness)* _____

EMOTIONAL ASPECTS

EMOTIONAL STATE/CONTENTMENT OF CLIENTS _____

SIGNS OF WARMTH AND CARING BY STAFF _____

NATURE/EXTENT OF ACTIVE, POSITIVE STAFF/CLIENT INTERACTION *(verbal, learning, play)*

PROGRAMMES & ACTIVITIES

DAILY PROGRAMMES		YES	NO
ARE DAILY PROGRAMMES AVAILABLE?			
IF YES: INDIVIDUALISED?	*(Tick YES for both if both apply)*		
GROUP?			

WHAT DO THE DAILY PROGRAMMES COMPRISE? *Comment on nature/appropriateness of activities*

ARE THERE **SPECIAL DAILY PROGRAMMES** FOR CLIENTS WITH SEVERE PHYSICAL DISABILITIES?

YES	NO

WHAT DO THESE PROGRAMMES COMPRISE? *Comment on nature/appropriateness of activities*

ARE REGULAR TEAM MEETINGS HELD TO PLAN/REVIEW PROGRAMMES & CLIENT GOALS/ PROGRESS?

YES	NO

IF YES, HOW OFTEN?

WEEKLY	MONTHLY	3-MONTHLY	LESS

COMMENT:

DAILY PROGRAMMES (ALL CLIENTS)	YES	NO
DID YOU SEE ASPECTS OF THE PROGRAMMES BEING CARRIED OUT?		
DID PARTICIPATING CLIENTS SEEM: FAMILIAR WITH THE ACTIVITIES?		
HABITUATED TO THE ACTIVITIES?		

WHICH ASPECTS OF THE PROGRAMMES WERE BEING CARRIED OUT? *Comment on numbers involved and quality of intervention*

ARE **SPECIAL EVENTS** ARRANGED FROM TIME TO TIME?
(e.g. outings, sports competitions with other facilities)

YES	NO

IF YES, WHAT AND HOW OFTEN?

THERAPIES

	PHYSIO	O.T.	OTHER *specify*
WHICH THERAPIES ARE AVAILABLE? *Tick if available*			
IF YES: INDIVIDUAL? *(Tick both if both apply)*			
GROUP?			
HOW MANY CLIENTS ATTEND *INDIVIDUAL*: daily			
at least once/week			
(in the past year) for brief assessments/consultations			
HOW MANY CLIENTS ATTEND *GROUP*: daily			
at least once/week			
HOW MANY WERE SEEN ATTENDING: individual?			
group?			

COMMENTS:

MEDICAL/PSYCHIATRIC ATTENTION

HOW OFTEN ARE CLIENTS:

ROUTINELY SEEN BY A MEDICAL DOCTOR?	
ROUTINELY SEEN BY A PSYCHIATRIST?	

WHAT ARRANGEMENTS ARE THERE FOR DEALING WITH MEDICAL/PSYCHIATRIC EMERGENCIES?

10. NUTRITION

Residential care and, if applicable, day care

	YES	NO
ARE THE DIETS NUTRITIONALLY BALANCED		
IS THE MENU VARIED?		
ARE DIETS APPROPRIATE TO:		
MEDICAL CONDITIONS		
CULTURE		
RELIGIOUS BELIEFS		

COMMENTS:

11. LINEN & BATHING REQUISITES

Residential care only

ARE THERE ADEQUATE SUPPLIES OF:	YES	NO
BED LINEN & BLANKETS		
TOWELS		
FACE CLOTHS (one per client)		
TOOTH-BRUSHES (one per client)		

IF NO, COMMENT:

12. PHYSICAL ENVIRONMENT

FACILITY

ARE THE FOLLOWING ITEMS:	SUITABLE#		HYGIENIC		MAINTAINED	
* *Required for residential only*	YES	NO	YES	NO	YES	NO
FACILITY AS A WHOLE: INSIDE						
OUTSIDE						
VENTILATION						
WATER SUPPLY						
HOT WATER SUPPLY						
COLD WATER SUPPLY						
ABLUTION FACILITIES						
IN GENERAL						
TOILETS						
WASH HAND BASINS						
* BATHS/SHOWERS						
DORMITORIES/SLEEPING AREAS						
* BEDS & BEDDING						
* PERSONAL SPACE						
LOCKERS						
COOKING/DINING FACILITIES						
IN GENERAL						
DINING AREA/S						
* PANTRY/IES						
SCULLERY/WASHING FACILITIES						
STORAGE AREA						
COLD STORAGE						
EQUIPMENT (cooking, eating)						
PROTECTIVE CLOTHING FOR STAFF						
WASTE DISPOSAL						
REFUSE						
SEWERAGE						
PROGRAMME AREA/S						
FLOOR SPACE						
EQUIPMENT						
THERAPY AREA/S (where applicable)						
FLOOR SPACE						
EQUIPMENT						
OTHER						
RECREATION/PLAY FACILITIES: OUTSIDE						
: INSIDE						
OFFICE FACILITIES						
* STAFF DINING AREA						
STAFF REST AREA						

 # includes reference to floor space where relevant

DETAILS, IF NO TO ANY OF THE ABOVE:

IS / ARE THERE ANY:	YES	NO
OBVIOUSLY UNPLEASANT SMELLS		
UNPLEASANT SIGHTS		
UNACCEPTABLY LOUD NOISES		
NOTICEABLE AIR POLLUTION		

DETAILS, IF YES TO ANY OF THE ABOVE:

SAFETY FEATURES

ARE THE FOLLOWING ITEMS:	AVAILABLE		SAFE		ADEQUATE	
	YES	NO	YES	NO	YES	NO
BURGLAR PROOFING ON WINDOWS						
SECURITY GATES ON OUTSIDE DOORS						
PERIMETER SECURITY WALL/FENCES						
WALL PLUGS						
GLASS DOORS						
FLOORS						
FIRE ESCAPE/S						
FIRE EXTINGUISHERS						
IS THERE AN EVACUATION PLAN?						
IS THIS PRACTISED?						

DETAILS, IF NO TO ANY OF THE ABOVE:

12. GENERAL IMPRESSION OF THE INSPECTORATE

ASPECTS TO BE RECTIFIED

ASPECT	BY DATE
NEW RECOMENDATIONS	BY DATE
Name:-	
Signature:-	
Date:-	