Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Clann Mór 1
Name of provider:	Clann Mór Residential and Respite Company Limited by Guarantee
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	11 and 12 July 2022
Centre ID:	OSV-0004928
Fieldwork ID:	MON-0030323

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Clann Mor Residential 1 comprises of four community based residential homes which are all located some miles from each other but close to small towns in county Meath. The centre supports up to thirteen adult residents both male and female with intellectual disabilities, some of whom live semi independently and others who require staff support on a 24 hours basis. All four properties are currently based on single bedroom occupancy, with access to the normal domestic dwelling facilities typically available in the local community. All houses have access to garden areas for recreation and leisure. The staff team is primarily made up of healthcare assistants. Community employment workers are also in place who work under the supervision of staff in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 11 July 2022	10:00hrs to 16:30hrs	Sarah Cronin	Lead
Tuesday 12 July 2022	09:45hrs to 16:30hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This was a two day inspection which was undertaken following the provider making an application to vary their conditions of registration in order to open two new properties as part of this centre. The inspector had the opportunity to meet six residents across three houses over the course of the inspection and spoke to with two family members by phone. The inspector found that residents were living in comfortable homes and that they appeared to be content. Residents had active lifestyles and attended day services and did a number of other activities of their choosing while at home. It was evident that staff and residents knew each other well and interactions were noted to be respectful, friendly and kind. However, there were a number of regulations which were found non-compliant on this inspection such as risk management, governance and management, contracts of care, infection prevention and control and personal possessions.

The centre currently comprises three houses in one location and one house in a neighbouring town. There are 13 residents with varying support needs living in these houses. The inspector visited three of these houses over the course of the inspection. The first house is a two-storey house with five bedrooms. Two of the bedrooms were downstairs in addition to a small toilet and a kitchen area. The back garden was beautifully maintained and there was space for residents to sit if they wished to do so. Upstairs there were two resident bedrooms, one of which was en-suite, a bathroom and a staff office. There were four residents living in the house and the inspector had the opportunity to meet all of them. Two of the residents had returned from a day trip and told the inspector that they had been for a picnic in the sunshine. Another told the inspector about an appointment they had attended and that they liked going to work. Another spoke about the support she had received from management with a personal matter that day. Residents told the inspector that they enjoyed living in the house and they got along well. This was evident in how they interacted with each other in the group. Each resident cooked for the other residents once a week and spoke about what they planned to make. Their bedrooms were decorated in line with their wishes. Personal effects and photographs were throughout and residents had ample space to store their belongings.

Two of the other houses were located in a nearby town. Each house had three residents living in it and the inspector met with four of the residents who were present on the day. The houses had a shared back garden and it was possible to enter house via sliding doors into each kitchen. The back garden was beautifully decorated with a large mural on the wall. One resident had made a fairy garden and another had a vegetable patch. There was a large garden room which one of the residents used as an art studio. The first house has two resident bedrooms upstairs, a bathroom and staff sleepover room while downstairs has an accessible shower room, a resident bedroom, kitchen, sitting room and a toilet. There was beautiful art work done by a resident on the walls in addition to some up -cycled furniture which another resident had done. Residents in this house reported that they were very happy living there and described the staff as "helpful" and "great". Another said that

they were like a big family and that they all got along. Each of the residents attended a day service five days a week. Since the last inspection, one of the residents who was a keen artist was supported to open a social media account to sell their art work. They were due to attend an upcoming craft fair to display and sell their work. One of the residents went shopping for the day with a staff member and spoke excitedly about their birthday plans.

The third house is a two-storey house with three resident bedrooms upstairs and a bathroom. Residents in this house were independent and needed a low level of support from staff. There were no staff in the house at night-time. One of the residents had been supported to purchase and learn to use an emergency call button while another used a device in their bedroom which called through to staff in the adjoining house if there was any difficulties. One resident who had recently moved in took the inspector to their bedroom. They used Lámh, gesture and facial expressions to communicate. They showed the inspector their new bedroom which was decorated with their photographs, their important possessions and they had ample space for their clothes. The resident smiled as staff supported them to tell the inspector about their family and their home-life. They later said goodbye to the inspector and went shopping on the bus. They appeared very happy and content.

The inspector received 6 questionnaires which were circulated to the person in charge in advance of the inspection. The questionnaire asks for resident feedback on a number of areas including general satisfaction with the service being delivered, bedroom accommodation, food and mealtime experience, arrangements for visitors to the centre, rights, activities, staff supports and complaints. Residents reported that they were mostly happy about the services they received. They did activities such as gardening, going out for coffee, dance classes, shopping and baking and meeting up with family and friends. Some reported that they did household chores. They described the staff as "nice" and that they would "go out of their way to support me". Another said " I have good control, I decide for myself". Two family members spoke with the inspector by phone. Both of them reported to be very happy with the care and support received by their loved ones. They said they felt welcome when they visited and that they knew their family member was content in their homes. Both told the inspector that they had no issues with raising any concerns and felt they were listened to where they did so.

It was evident to the inspector that residents were supported to participate in the running of their home. Photo staff rotas were in place in all of the houses and for some residents, schedules were in place to support them with their routines. A residents meeting took place every three weeks and there was a set agenda in place including COVID-19, house information, activity plans and a number of other areas. Residents were supported to do the grocery shop, to cook and clean where they wished to do so and to engage in activities they enjoyed. One resident told the inspector that they felt they were supported with their rights and that "was a good thing". The provider had a resident advocacy forum in place, with a representative attending board meetings as appropriate.

In summary, from what the residents, staff and families told the inspector, what the inspector observed and a review of documentation, it was evident that residents had

a good quality of life in the centre. They were well supported by staff to do activities of their choosing. All of the residents were well presented and appeared very content and comfortable. The next two sections of this report present the inspection findings in relation to governance and management of the centre and how these arrangement affected the quality and safety of the service being delivered.

Capacity and capability

The provider had management systems, structures and processes in place to monitor and oversee the service. However, improvements were required to strengthen these arrangements. The Board of Directors met with management on a monthly basis and had a number of subcommittees in place for specific aspects of the service such as quality and safety and risk management. There were emergency governance arrangements in place. Since the last inspection the provider had appointed a person in charge who worked on a full-time basis and was responsible for the day-to-day management of the service across five houses. There were systems in place to monitor the service, with audits carried out in areas such as personal plans, finances, medication and COVID-19. The inspector found that these audits were not self-identifying areas for improvement. The annual review and six-monthly unannounced visits and reports were not done in line with regulatory requirements.

As previously mentioned, this inspection was undertaken following an application to vary this centre to include two new properties and to assign an existing house to another designated centre. The person in charge was to be supported by a coordinator of the three houses in one location. However, delineation of these roles and responsibilities was unclear. The inspector was not assured that the governance and management arrangements in place for the expansion of the centre were adequate. Following the inspection, the provider amended their application. They planned to register a new designated centre to include two new houses and an existing house in one location. They gave assurances to the Authority that they planned on putting a person-in-charge in that location in order to ensure adequate monitoring and oversight of the services and the opening of two new houses.

The houses in the centre were found to be resourced with an appropriate number of staff who had the qualifications and experience to support residents with their assessed needs. Staff were found to have completed mandatory training in line with the provider's requirements. Supervision and performance management arrangements were in place.

The provider had a policy on the admissions and contract for the provision of services. The inspector found that there was no financial assessments carried out to ensure that residents' fees were in line with their income. There were contracts of care in place which outlined what fees covered in a broad sense but this was unclear in areas such as equipment for residents, arrangements for purchasing items in the

house in communal areas and on charges where a resident was absent from the centre.

Regulation 15: Staffing

Houses which were in operation in the centre were found to have adequate numbers of staff in place to meet the assessed needs of the residents. Staff were found to be knowledgeable about residents' assessed needs. Planned and actual rosters were well maintained and indicated that residents enjoyed continuity of care in their homes.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector viewed the staff training matrix and found that staff had completed mandatory training in the areas of fire, safeguarding, food safety, safe administration of medication and in infection prevention and control. Staff were supervised three times a year and a performance review took place on an annual basis. Each quarter, the provider had a staff training session on a topic of interest. A sample of supervision notes were viewed by the inspector and these indicated that sessions were structured, with a set agenda including personal care, medication, paperwork, training and challenges. A log of supervision actions were kept and reviewed at each session. For staff starting induction, there was a checklist in place for mandatory training and for in-house sessions to ensure they were familiar with emergency precautions, residents' needs and how to perform their duties in the house.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the governance and management arrangements which the provider had in place were not adequate to ensure effective monitoring and oversight of each of the houses. The provider had recently appointed a person in charge for the centre who was supported in their role by community facilitators in each house. In order to oversee the opening of two new houses, the provider had proposed a new coordinator role to support the person in charge with three of the five houses in the designated centre. It was unclear what the delineation of these roles would be and the inspector was not assured that adequate oversight of two

new houses would be achieved.

Regular management meetings took place with team leaders, persons in charge and members of the senior management team. These meetings were used to discuss quality and safety of care for residents, COVID-19, service developments and incidents and accidents. There were emergency governance arrangements in place for staff working out-of-hours. There were a number of audits were taking place in order to monitor various aspects of the service. However, these were not identifying areas for improvement. For example, in one house, there were financial audits done which did not identify that there were a large number of signatures missing from an income and expenditure sheet.

The provider had not carried out the annual review or six monthly unannounced visits as required by the regulations. Persons in charge had carried out the annual review for the centres, with each person in charge rotating to another house to do so. While there was evidence of interviews taking place between members of the the board and residents and families to inform the annual report, this was not discussed in the report. The reports were not made available to residents and families. The six monthly visits had been carried out and an action plan was developed for each of these visits. However, as there was not a written report, it was unclear how these judgments were made or what the findings were. A copy of the annual report was not provided to residents and their families.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had a policy on the admission, transfer, discharge and temporary absence of residents. This outlined roles and responsibilities of staff members in addition to procedures in place to ensure that prior to an admission, all relevant information about a residents' assessed needs was received. The provider had a contract of care with each resident and a conditions of service which outlined roles and responsibilities of the provider and of the resident. The contract and the statement of purpose outlined the fee payable which was the same amount for all residents. Residents' income had not been assessed to ensure that the fee was affordable for them. The contract of care did not provide adequate detail on what fees residents were responsible for in relation to communal items and equipment they required.

Judgment: Not compliant

Quality and safety

The inspector found that residents were enjoying a good quality of life in the centre. They attended day services and were supported to do activities of their choice in addition to being active participants in their homes. It was clear that residents' rights were considered and upheld within the organisation.

Residents were found to be well protected from abuse in the centre. Staff were trained in recognising the signs of abuse and appropriately reporting them. Any safeguarding incidents were found to have been reported and investigated in line with national policy. However, measures in place to ensure accurate recording of residents' finances and staff ensuring that they used the provider's procedures for staff signatures on receipts required improvement to ensure residents' finances were safeguarded at all times.

As previously mentioned, some of the residents required communication supports to ensure that they understood information about their routines and that they were supported to express themselves. Staff and residents were trained in the use of Lámh and used it with a resident. Residents were found to have control over their personal possessions. However, residents who required support with their finances did not have assessments in place to inform their money management plans.

All of the premises visited were warm, clean and homely. They had personalised bedrooms for residents, adequate bathing and showering facilities, space for residents to receive visitors or spend time with other residents and beautiful garden spaces. One bathroom was identified by the inspector as requiring refurbishment. However, this was identified by the provider and plans to seek funding were in place.

Risk management systems required improvement. Risk registers at corporate, centre and individual levels were found to contain different risks relating to residents. Some risks were not identified and assessed to ensure all risks were mitigated against. There was a system in place to report adverse events. Incidents were reviewed regularly by senior management and acted upon appropriately.

The provider had put a number of policies and procedures in place to manage risks associated with COVID-19 and staff demonstrated good knowledge of contingency planning and responses to cases of COVID-19. There was an infection prevention and control policy in place but this did not contain adequate information on IPC measures to guide staff practices. The inspector found some practices to require improvement such as ensuring that all equipment, including cleaning equipment was on cleaning schedules and in antimicrobial stewardship.

Fire systems and procedures were reviewed in each house. All houses had detection and containment measures in place in addition to fire fighting equipment and emergency lighting. Residents had personal emergency evacuation plans in place and documentation of drills had improved since the last inspection.

Medication management was found to be of good quality in the service. There were clear systems in place for the prescribing, ordering, storing and administration of medication. Medication errors were reported and there was a protocol in place to

ensure these errors were swiftly followed up on to ensure staff members' competencies remained at an acceptable level to administer medication safely. Residents who wished to self-medicate were supported to do so in line with their assessment and medication plans.

Regulation 10: Communication

The inspector found good practices in ensuring that all residents were supported to communicate in a method of their choice. Photo staff rotas were used in all houses. For other residents, there were visual schedules used to support them to understand and remember their routines. Another resident was a Lámh user and staff were noted using Lámh with the resident. Another resident had been shown the relevant signs to use with them and was noted to interact with the resident using Lámh.

Judgment: Compliant

Regulation 12: Personal possessions

For the most part, the inspector found that residents were supported to retain control over their personal possessions. Each resident had an inventory of personal possessions. Bedrooms had ample space for residents to keep their clothes and personal affects. They were decorated in line with their preferences. Financial support was provided to residents who required it and there were money management plans in place. However, these support plans were not informed by assessment and therefore did not give sufficient direction to staff, particularly in relation to the use of ATM cards.

Judgment: Not compliant

Regulation 17: Premises

All of the houses in the centre were found to be very homely, warm and well-maintained. Since the last inspection, minor repairs were carried out in one of the kitchens and the carpets in two of the houses had been replaced. In one of the homes, a bathroom required remedial works on the floor, the bath and the boxing behind the toilet which was cracked. However, this was identified by the provider and they were in the process of getting funding to carry out works. A maintenance log was kept and each house had allocated maintenance time each week to enable small jobs to be completed. Each premises was designed and laid out to meet the aims and objectives of the service. Residents had their own bedrooms, all of which

were reflective of their interests and life histories, with family photographs and personal effects throughout. There were suitable arrangements in place for the management of waste and laundry.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place which contained all information required by the regulations. Each centre had a risk register in place and there was a corporate risk register in place. Some risks were not recognised or assessed in relation to resident-related risks such as aspiration and diabetes. The risk register was reviewed on a monthly basis. However, closed risks and older control measures remained on the register, meaning that the control measures were not clear for staff. Clear risk assessments were not carried out for all risks on the risk register to ensure that there was adequate information available for staff. Adverse events were appropriately recorded, documented and investigated. The provider analysed incidents and ensured follow up actions were completed in a reasonable time frame. Incidents were discussed with individual staff or the staff team as appropriate.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had developed a COVID-19 preparedness and outbreak management plan. There were clear procedures in place for staff to follow in the event of a suspected or positive case of COVID-19. Staff were found to be knowledgeable on standard-based and transmission-based precautions. They described to the inspector how they had recently managed two cases of COVID-19 in the centre. They told the inspector about how they managed cleaning and disinfection in the centre and the management of laundry.

It was evident that weekly discussions took place with residents about COVID-19 and that informed consent was sought for vaccinations. Up-to-date information was shared with staff using memos. The inspector viewed the policy on infection prevention and control and found that it was not sufficiently detailed to guide staff practice in a number of areas such as the management of linen, the management of spillage of body fluids, standard and transmission-based precautions. There was a focus on COVID-19 and other healthcare-associated infections were not contained in the policy. Legionella was not noted as an IPC risk on risk registers and water checks did not take place. Cleaning schedules did not contain all equipment in the house, including the cleaning equipment and health-care equipment such as nebulisers and a glaucometer. While there was a record of all antibiotics taken by

residents in their individual plans, there were not governance arrangements in place to monitor this at centre or organisational level.

A review of outbreaks took place at management teams but it was not evident from staff team meetings that reflection and learning was shared to ensure actions were taken where required. Regular audits took place of centres relating to COVID-19 and a maintenance log was kept up to date. On one of the premises, the bathroom required renovation and therefore, was difficult to thoroughly clean in parts. This posed an IPC risk. Additionally, many of the bins in houses had not been replaced in line with the provider's compliance plan from the previous inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had good fire safety systems in place. Detection and containment measures such as fire doors and smoke alarms were installed in each house. Houses had fire fighting equipment and emergency lighting, all of which were in good working order. Regular checks and services of all equipment took place. Each resident had a personal emergency evacuation plan (PEEP) documented. The provider had improved documentation of fire drills since the last inspection and were using different scenarios with staff and residents to ensure that they continued to develop skills in ensuring safe evacuation of residents in a range of conditions. Weekly fire drills and education sessions had taken place with a resident who was new to the centre to ensure they were able to evacuate safely in the event of a fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider was found to have good systems in place relating to medication management in the centre. There were clear systems for the ordering, prescribing, receipt and storage of medication. The medication administration records for a number of residents were viewed. These were clear and well maintained. Information about each medication was available to staff. Residents had assessments carried out to ascertain the level of support they required to self-medicate.

The provider had a clear system to manage medication errors. Errors were recorded and immediately notified to management. Where there was an error, the staff member had a supervision specific to medication carried out by a nurse in the organisation. Where there were repeated errors, this was reviewed as a

performance management issue or disciplinary matter.

Judgment: Compliant

Regulation 8: Protection

The inspector found that residents were protected from abuse in the centre through policies and procedures relating to safeguarding, personal possessions, the provision of personal and intimate care and communication with residents. All of the residents who spoke with the inspector reported that they felt safe in their homes. This was corroborated by family members who the inspector spoke with.

Where safeguarding incidents had occured in the centre, the inspector found that these had been identified, reported and documented in line with national policies. The inspector viewed a number of intimate and personal care plans and found them to be appropriately detailed to ensure each resident received support in line with their assessed needs and which respected their rights to privacy, dignity and bodily integrity.

As noted earlier in the report, there were systems in place to support residents with their finances. However, some staff practices such as signing of receipts, checking balances with two staff members and clarity on the amount of cash held on the premises were not in keeping with the organisation's policy. Therefore, the inspector was not assured that residents' finances were fully safeguarded in the centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Clann Mór 1 OSV-0004928

Inspection ID: MON-0030323

Date of inspection: 12/07/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Clann Mór are going to apply to HIQA for a new designated centre and a reconfiguration of Clann Mór 1.
• Clann Mór 1 will consist of three houses (Windtown 5, Windtown 14 and Dunloe),
• Clann Mór 2 will not change.
• Clann Mór 3 (new designated Centre) will consist of two new houses (Cherry Hill 1a, Cherry Hill 2) and our existing house in Kells (Headfort Woods).

Audits:
Audits are going to be enhanced to identify areas of improvement.
Team Leader/PIC (TL) will meet monthly with Community Facilitators' (CF's) to review audit findings and actions required.

Finances:
A memo will be circulated to all staff to reinforce the protocols for financial procedures.
TL will speak to all staff individually over a 4 week period to re enforce financial controls
CF and TL monthly audits will be enhanced to ensure that financial protocols are adhered to

Annual report:
Annual report to be completed by Service Manager. A six-monthly unannounced report will be drafted from existing data collected during these audits. A summary of the annual report will be made available to all families and residents as part of the AGM report.

A summary report of the six-monthly unannounced inspection will be created. This will be created for January – June 2022 for CM1.

Incident reports:

Incident reports will be discussed weekly at management meetings.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Residents' income will be assessed to calculate the weekly contribution they will pay.
The contract of care will provide enhanced details of what Clann Mór supply/provide and what resident are responsible for financially.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Each resident will have an individual money/finance assessment.

The resident money management plan will be enhanced to outline exactly what supports are needed by the resident.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
House risk register – all closed risks will be archived. All not relevant information (e.g., Covid information for 2021 will be deleted, so that only current information is presented.

Corporate risk register – All risks relating to individual residents in the risk register will have an associated risk assessment. Resident's Unique ID numbers will be used to ensure anonymity.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
IPC policy will be reviewed to include more enhanced details e.g. management of linen, spillage of body fluids etc. Standard and transmission precautions are to be outlined also.
A legionella risk assessment will be created and thereafter reviewed regularly. This risk will also be on the corporate risk register. Water checks will be carried out annually.

Existing house cleaning schedule will be enhanced, where necessary to include all health care equipment e.g. wheelchair, hand rails, nebulizers etc.
Antibiotics – all antibiotics are recorded in the following locations:
- Notes on visits to health professionals
- Associated healthcare plans
- Resident daily diary
- Staff will email TL when an antibiotic is prescribed who will monitor usage.

• Use/prescribing of antibiotics will be discussed at weekly management meetings.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: A memo will be circulated to all staff to reinforce the protocols for financial procedures and policy will be enhanced with additional protocols.TL will speak to all staff individually over a 4-week period to re enforce financial controls. CF and TL monthly audits will be enhanced to ensure that financial protocols are adhered to.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	26/08/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	26/08/2022
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	26/08/2022

	ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	26/08/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	16/09/2022
Regulation 23(1)(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Not Compliant	Orange	16/09/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall	Not Compliant	Orange	16/09/2022

	carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Not Compliant	Orange	26/08/2022
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the	Not Compliant	Orange	26/08/2022

	support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	26/08/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	26/08/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of	Substantially Compliant	Yellow	26/08/2022

	abuse.			