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:	Clannad
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	15 November 2021
Centre ID:	OSV-0005633
Fieldwork ID:	MON-0030275

About the designated centre

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

Clannad is a residential centre located in Co. Kilkenny. The centre affords a service to four adults, both male and female over the age of 18 years with an intellectual disability. The service operates on a 24 hour 7 day a week basis ensuring residents are supported by care workers at all times. The day to day operations of the service are provided by a clear governance structure. Supports are afforded in a person centred manner as reflected within individualised personal plans. The residence is a detached bungalow house which promotes a safe homely environment decorated in tasteful manner.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 15 November 2021	10:00hrs to 17:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

The governance and management arrangements in place were not effective at ensuring a quality driven service was available to residents. The inspector found that the service was not effectively self-identifying quality improvement areas. Levels of non-compliance were identified across a number of regulations which, at times, negatively impacted the lived experience of residents. This centre was previously inspected in March 2020 and since this time there was an overall deterioration with levels of compliance with regulation.

The centre was located in a rural setting in Co. Kilkenny. It comprised a detached bungalow building surrounded by a very large garden area. As the inspector approached the front door it was noted to have a number of cobwebs, dirt and other debris surrounding the door, windows, and the eaves of the home. It was evident that this part of the home had not been recently cleaned. Internally the home had two sitting rooms, a small kitchen, four separate bedrooms, one bedroom was en suite, and a main bathroom.

The overall impression of the home was that it required works both internally and externally. There were cleanliness issues noted in a number of areas of the home. On the walk around of the home, dust accumulations were noted in a number of areas indicating the premises had not been cleaned to a high standard, stains were evident on sinks, floors and other bathroom equipment. Paint on walls and furnishing was chipped in many areas of the home. The main bathroom had been recently tiled and floored, however, other parts were noted to be in poor condition. Casing around pipes near the toilet was chipped and stained and in general poor condition. Mirrors were stained and rusted. One resident's bedroom had a damp patch on the ceiling. A door stopper was missing from a door and a nail was being used to stop the door hitting the wall. Very few personal items were on display in the home specifically in communal areas.

Cleanliness issues were also noted in an attached garage, were residents completed their laundry (which was a hygiene concern). This garage was used also for storing items including the waste management system for the home. Large cobwebs were noted throughout the area and it did not present as a clean, well kept area.

The large garden outside did have an overall well kept lawn. However, a very large mound of grass was located at the side of the home. An area beside this was significantly overgrown. There was a septic tank located in the front garden. Two open/uncovered pipes from this system were sticking out of the grass. The person in charge was not aware how long it had been like this or the reason why it had been left uncovered.

The inspector had the opportunity to meet with all four residents in the home. Different means of communication was used by all four residents, including verbal means, adapted manual signing communication system, gestures, vocalisations and

facial expressions. Staff were familiar with residents' individual means to communicate and interpreted the signs a resident was using with ease.

A resident had an upcoming hospital appointment with surgery scheduled. It was noted throughout the day that the resident went to seek assurances from staff in relation to when this appointment was, and who was attending the appointment with them. Staff were seen to respond appropriately to the resident when they requested information.

A resident had a cup of tea with the inspector in the kitchen. They requested information from staff in relation to upcoming plans and seemed anxious at times. All staff responded in a consistent manner and informed the resident that they would make a plans closer to the time of the event.

The two other residents remained in their respective sitting rooms for the majority of the day. They choose not to interact with the inspector. Although each resident was brought out separately for short period of time during the day, observations indicated that minimal activities were offered to some residents in the home. Some residents were left for long periods of time on their own in front of tv with minimal staff interaction. A review of a sample of daily notes indicated that residents were brought out in the community to enjoy activities such as walks, drives and personal shopping. Home visits were also noted. However, following observations across the day and documentation review of daily notes and social goals the inspector was not satisfied that meaningful activities were being provided to residents on a consistent basis.

The inspector was also not satisfied that the compatibility of some of the residents had been reviewed in the house. Throughout the day, two residents used loud vocalisations directed at each other, even when in different parts of the home. At one point, a resident was noted to close a door following a resident shouting from another room. From speaking with staff throughout the inspection, it was discussed that this occurred on a regular basis. Later in the day these two residents were present in a room with the inspector. There were no other staff present in the room. The residents began to use loud vocalisations towards each other which culminated in a safeguarding incident. Once staff were informed of the incident they redirected each resident and reassured each person. Due to residents been left for periods of time on their own, some residents limited communication skills and general staff knowledge around safeguarding, the inspector was not assured that safeguarding incidents were being recognised as such and investigated in line with national policy. The above incident was later reported to the Chief Inspector and investigated in line with the organisation's policy.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall the inspector found that the centre did not have adequate governance and management systems in place to ensure residents were provided with a good quality service that enhanced their quality of life experience. 12 regulations were inspected against with 11 of these regulations requiring improvements. Significant improvements were required in the development and implementation of effective management systems to ensure appropriate oversight and delivery of services that were of a good standard, consistent and appropriate to the needs of residents.

The inspector reviewed the provider's systems to monitor the quality and safety of care and support provided as required by regulation. These included carrying out unannounced provider visits at six-monthly intervals, with such visits reflected in written reports. However, despite the provider conducting unannounced inspections and an annual review of quality and care, the provider failed to self-identify critical issues identified during this inspection. This highlighted that the arrangements in place were insufficient to drive the quality improvement required to enhance residents lived experience within the centre.

It was noted that there were significant gaps in the time lines of audits being completed, for example, a health and safety audit had been completed in February 2020. No audit had been completed since this date. A vehicle audit was completed in February 2020 and next audit completed was in October 2021. This audit had only partially been completed. Audits were failing to identify critical issues and if they were identifying issues these were still present on the day of inspection and had not been rectified. These systems had limited oversight of the care and support being provided to the residents.

There was sufficient staff on duty on the day of inspection. Two staff were rostered during the day and one waking night. A review of the rosters indicated a continuity of staff was provided to residents with the existing staff team providing cover for any staff absences. Policies were in place to guide supervision of staff practices known as quality conversations. Supervision was not occurring in line with the organisation's policy. A sample of records reviewed indicated that some staff had not had formal supervision in three years.

The training records were reviewed. These records indicated that staff were required to have specific mandatory training completed. Some of this included, safe administration of medication, fire safety training, emergency first aid, safeguarding vulnerable adults and managing behaviour that is challenging. In addition to this the provider had also listed training that was specific for staff to have completed to work in this designated centre such as managing feeding, eating, drinking, and swallowing training, and specific sign language training. Not all staff had completed training and/or refresher training in a small number of areas.

Regulation 15: Staffing

The registered provider had ensured that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

The training records viewed indicated that staff had completed the majority of mandatory training. Some of this included fire safety, hand hygiene, safeguarding vulnerable adults, and challenging behaviour training. However, the records viewed indicated that a number of people had not completed up to date training in managing behaviours of concern. They were booked to complete this in the coming weeks.

In addition to this specific communication training had been identified as a requirement to work in this home. A number of staff had not completed specific training in this. This also had been identified in the previous inspection in March 2020.

Staff were not receiving supervision in line with the time lines specified in the registered providers policy. A review of a sample of supervision notes indicated that some staff had received supervision in recent weeks. However, previous supervision sessions had occurred in early 2020 and for one staff member the previous supervision record was dated 2018. The organisations policy stated supervision was to occur a minimum of 3 times per year.

Judgment: Not compliant

Regulation 23: Governance and management

Taking into account findings under the regulations during this inspection, the provider's monitoring systems were not ensuring that the service provided was safe, appropriate to the needs of all residents' needs, consistent and effectively monitored.

There was a marked absence of systems in place to ensure the consistent oversight and monitoring of care and support in the centre. The systems that were in place were not being consistently implemented in the designated centre. While audits were occurring they were not identifying some of the critical areas for improvement identified during this inspection. For example no health and safety audit had been completed since February 2020. A number of significant risks were identified on the day of inspection, such as storage of combustible products and gases. Risk management systems required improvement and further oversight.

If audits were identifying areas of improvement they appeared to not be acted upon. For example a hygiene audit completed in August 2021 had identified similar findings to that found on the inspection day. On review of this audit it was note that actions were not delegated to a a particular staff member and the manager signature on this audit remained blank. These cleanliness issues remained on the inspection day.

A lack of a comprehensive system of oversight was negatively impacting on the quality of care provided to residents.

Judgment: Not compliant

Quality and safety

The inspector found that this centre's governance and management arrangements did not ensure that the quality and safety of care delivered to residents was maintained to a consistently high standard. A number of non-compliance's with regulations were identified in relation to residents' health care, residents' rights, general welfare and development, risk management, protection against infection and fire precautions. Significant improvements were required to ensure a quality driven, safe service was provided to residents. At times residents' lived experience was impacted by the limited oversight of the service and the failure to drive quality improvement as part of the service delivery.

Due to the restrictions imposed during the COVID-19 pandemic, residents were not in attendance at their day service on a full time basis. Some residents could access aspects of the day service on a part-time basis. In addition to this, a staff member from the day service attended the residential service one afternoon a week to facilitate art. As the centre was located in a rural location there was a vehicle available for residents to use for community access. On the day of inspection, it was noted that some residents spent a large part of their day in front of the television with minimal activities offered. Each resident left the designated centre separately for approximately one hour. From a review of the daily notes, observations, and review of goals in the residents personal plans, the inspector was not assured that residents were afforded opportunities for meaningful activities on consistent basis. Residents were spending a large part of the day in the home with minimal in house activities being offered.

During observations it was noted that some residents used loud vocalisations directed towards each other. At one part of the day this culminated in a safeguarding incident occurring between two residents. As residents were spending a large part of the day in the home, and at times unsupervised, the inspector was not assured that previous incidents had not occurred. The potential impact of residents using loud vocalisations at each other had not been recognised as a potential compatibility issue.

Although individual and house specific risk assessments were in place, due to the findings on inspection the inspector was not assured that effective risk management procedures were in place. A small number of potential high risk practices were identified on the day of inspection, including the inappropriate storage of combustible gases and liquids. In addition to this, risk assessments were not being updated following significant incidents and events. Although learning had been identified and discussed, risk documentation had not been updated to reflect the relevant information.

Fire precaution measures were reviewed by the inspector, who found that there was a fire alarm and detection system in place along with appropriate emergency lighting. Fire containment measures were in place with fire doors and automatic closures. There were personal emergency evacuation plans in place for each resident, which outlined the individual supports required in the event of a fire or similar emergency. It was found that a procedure outlined in this plan could not be effectively completed when the minimum number of staff were present during the night.

A sample of residents personal files with were reviewed. It was found that one resident had not had their yearly health assessment. In addition to this there were gaps found in the documentation in relation to residents access to chiropody appointments. Although annual visioning meetings had occurred to review residents' personal and social goals, goals that had been identified had limited evidence to indicate if they had been progressed to date.

Regulation 13: General welfare and development

Although residents had some opportunities to engage in some meaningful activities across the day such as taking part in household chores, going for drives and walks, and shopping. Observations on the day of inspection indicated that residents were not offered or engaged in any meaningful activities for large parts of the day. For example, one resident sat in the sitting room for the most part of the morning. it was noted that no staff member offered any type of meaningful activity. The first observed staff interaction was when the resident was called to go into the kitchen for their lunch. Social goals identified in the residents personal plans, however, there was limited evidence to indicate if any of these goals had been progressed since they had been identified in early October.

Judgment: Not compliant

Regulation 17: Premises

The premises required internal and external maintenance works to ensure it was a

homely, well kept environment. Externally it was noted that windows, doors and eaves around the home had not been cleaned. Areas of the garden required attention as a large mound of grass was left on the lawn, one area of the garden was overgrown, elements of a septic tank were visible in the front garden and also posed a potential risk as pipes were sticking out from the ground.

Internally, paint work was chipped on walls and furniture throughout the home. Bathrooms had stained materials such as floors and wooden casings around pipes. A large damp patch was present on a resident's bedroom ceiling. There were limited personal items on display. Parts of the home required a deep clean, this will be addressed in Regulation 27.

Although the kitchen could sit the four residents, space was very limited. Some residents were presenting with declining mobility. The long term suitability of this part of the home required review to ensure it would be accessible to all residents that required mobility aids.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspector found there was limited oversight of risk in the centre. A small number of high risk practices were identified on the day on inspection that had not been identified or managed in line with the organisation's risk management policy and procedures.For example, hand sanitiser was being stored in a hot press, a gas cylinder was being stored beside a working dryer and an exposed nail was sticking out from a wall and was being used as a door stop. Each of these practices had the potential to impose different levels of risks to the people living in the centre.

Although individual risk assessments were in place, some risk assessments were not updated following a significant incident or event. For example a resident had a falls risk assessment in place. This had not been reviewed following a witnessed fall. Specific learning had been recorded in the incident form with a new control measure identified. The new control measure had not been reflected in the risk assessment.

Judgment: Not compliant

Regulation 27: Protection against infection

A number areas of the home required cleaning with visible dust and dirt observed in a number of areas. The house was not been cleaned appropriately from observations made. Stains were evident on equipment used to store personal items. Chipped paint was evident on walls and furnishings. The condition of some areas of

the bathroom, such as casings around pipes were stained,chipped and in a general poor condition. Both the outside of the home and the vehicle required attention to ensure they were also regularly cleaned. The inspector was not assured that the premises was being cleaned to a standard that was in line with recommendations to ensure infection prevention control measures were effective.

Judgment: Not compliant

Regulation 28: Fire precautions

There were fire management systems in place such as suitable fire equipment, fire containment measures and adequate means of escape. Emergency lighting was in place to guide residents and staff to the designated fire exit. Fire drills were occurring at regular intervals.

However the storage of combustible materials required reviewed to ensure they were in line with effective fire mitigation procedures. This items were moved to a different location on the inspection day.

Although each resident had a personal evacuation plan, a procedure was described in a sample of plans that could not be utilised effectively as it would require two staff. Only one staff was present at night. On discussion with staff, it was noted that this procedure had never been used, however, plans required review to ensure the information/guidance was appropriate to an emergency situation. This required review to ensure all residents could be safely evacuated in the event of a fire with the lowest compliment of staff on duty.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each individual had a personal plan in place. Although assessments were in place for health, personal and social goals, a resident had not had a health assessment since April 2020.

An annual visioning meeting had occurred which identified residents' personal and social goals for the year ahead. There was evidence to indicate that the resident was included in this meeting. There was limited evidence in place to indicate the effectiveness of the goals chosen or their progress to date.

Judgment: Not compliant

Regulation 6: Health care

Overall, residents were supported to achieve and maintain good health, improvements were noted across a number of areas. As previously stated on review of a sample of plans, it as noted that one resident had not completed their annual health assessment. As this resident was under consultant care for an emerging health need they had been comprehensively reviewed in terms of some health needs. However, the registered provider had failed to complete an annual health assessment in line with the requirements of regulation.

In addition to this on review of a care plan in relation to chiropody needs indicated the resident required chiropody care on an eight weekly basis. Documentation of appointments indicate the resident had two appointments since March. The inspector was not assured that the resident was accessing this service in line with their assessed needs.

A resident had been referred to a health and social care professional following a health related incident in June 2021. The referral for this consultation had not been followed up on the residents behalf and there was no information provided or documentation available to indicate if any follow up had occurred since the health risk was identified.

Judgment: Not compliant

Regulation 8: Protection

Since the last inspection, no safeguarding incidents had been reported to the Chief Inspector. On review of the incident and accident book and daily notes no safeguarding incidents had been identified or recorded. However, on the day of inspection it was noted that two residents frequently used loud vocalisations towards each other. This culminated in a safeguarding incident that was witnessed by the inspector. This was subsequently reported to the Chief Inspector and investigated in line with the organisation and national policy. However, following conversations with a number of staff in regards to this and general observations on the day, the inspector was not assured that previous incidents were being recognised or responded to as safeguarding incidents. Staff had indicated that the residents frequently used loud vocalisations towards each other. The potential impact of this had not been considered or even identified as a possible safeguarding matter/compatibility issue. The inspector was not assured based on all evidence available that appropriate safeguarding practices were operational in this centre.

Judgment: Not compliant

Regulation 9: Residents' rights

There were times that the residents' rights to privacy and dignity were not always upheld. One resident's bedroom was at the front of the home. Although there was a blind present on the residents window, their preference was to keep this blind open at all times. The registered provider had not explored any other options to ensure the residents privacy and dignity was respected at all times.

On the day of inspection, a resident entered another resident's bedroom to use an en suite bathroom. No measures had been put in place to address this and to ensure that each residents' personal space was respected at all times. Discussions with staff indicated that this had occurred on a number of occasions.

Judgment: Not 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	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Clannad OSV-0005633

Inspection ID: MON-0030275

Date of inspection: 15/11/2021

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: As part of the providers and PICs action plan resulting from the most recent inspection, please find following update regarding training: - Three staff members from Clannad team have completed MAPPA training on the 01/12/2021. Three staff members are scheduled for completion on the 13/01/2022. - 2 staff members have already completed Lamh training. 6 more staff members will have completed Lamh training by the 19/01/2022. One staff member has been assigned to complete On the Job Mentoring with peer staff members in Clannad regarding Lamh and further implement the Lamh sign of the week in the designate centre to build capacity. SPC training schedule for 2022 is available to all employees in SPC and refresher training has been booked where identified. As part of the comprehensive action plan developed with the PIC and PPIM completion of all outstanding Quality Conversations had been highlighted as an urgent action. All Quality Conversations are now completed in line with SPC policy. The PIC is supported by the PPIM within her fortnightly governance meetings to oversee completion of Quality Conversation in both of the PICs designated centres.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
As a matter of urgency, the provider commenced action plan meetings immediately after the inspection took place to address all identified areas of concern.
Action plan meetings were held on the 16/11/21, 23/11/21, 8/12/21 and 17/12/2021 to review actions and completion of same, identify any further actions and steps to be taken and develop a robust Governance & Management plan with the PIC and PPIM.
Action plan meetings were attended by the Interim Director of Service, Quality Manager, PPIM and PIC.

The Interim CEO attended the action plan meeting on the 8/12/21 also to discuss not only the tasks addressed within the action plan but also look into more detail of the organisational responsibilities in relation to the identified issues and discuss to ensure a strong governance and management system in Clannad going forward.

Group discussed and agreed the following governance & management plan for PIC of Clannad and Country Lodge, supported by the PPIM to prevent these issues in the future:
1. PPIM and PIC meet fortnightly to discuss governance & management issues arising and workplan for PIC's both designated centres.
2. Periodic Service Review self-evaluation to be completed by PIC on a monthly basis and reviewed with PPIM to discuss workload, progression on tasks and oversight.
3. PPIM and cluster admin support to help PIC set up a robust system of management folder (in line with PPIMs system) for both of PICs designated centres. This folder system is guiding the PIC in her tasks and delegation of duties and show evidence and accountability when discussed at Quality Conversations and governance meetings. Action plans from audits, HIQA inspections for each designated centre, minutes of governance meetings, actions identified through Quality Conversations and delegated duties are outlined in the folder system to guide the PIC in managing her workload.
4. Thematic Quality Conversation checklist has been developed by Quality Manager and the PPIM to guide all PPIMs in their Quality Conversations in line with regulations.
5. PIC to avail of peer support from peer PIC to complete staff screening re identifying any training and support needs. This support to be provided on a weekly basis by peer PIC for the next weeks to implement the screening in Clannad.
6. Peer support from another peer PIC to complete 6 monthly unannounced visit in Clannad, mentoring the PIC in completing the audit and building capacity re oversight and management in relation to regulations and supports provided.
7. Quality Manager to link with SMT regarding management training for PICs, planned dates for 2022 to ensure PIC can avail of this training.
8. PIC to complete HSELand training re delegation. Enrolment in Management training course is booked for 01/02/2022 via HSELand.
9. PIC to ensure all staff have read and signed the HIQA report after being discussed.
10. PIC to link with another peer PIC re completion and scheduling of monthly reviews for people supported, share learning of a good system and implement in Clannad.

At the most recent meeting on the 17/12/2021 the following was discussed and agreed:
• Information to people supported and families regarding the HIQA inspection and findings outlined in the HIQA report.
• Actions identified through most recent house visits from Interim Director of Service and

PPIM.
• Agreement to meet for the next team meeting on 12/01/2022 in SPC offices Danville with staff team, Interim Director of Service, Quality Manager, PPIM and PIC to further discuss capacity building of staff team, responsibilities and accountability.
• Development of a Change Management Plan for Clannad, based on identified practices the PIC and PPIM want to change.

The next review meeting to review actions and progression of same is scheduled for 06/01/2022.

Further actions were agreed with Senior Management Team:
• Development of an organisational compliance management handbook.
• Senior Management Team to complete a full review with the Community Service Managers of the organisational non compliances on the 13/01/2022 and identify any further actions as needed.
• Research and implementation of a new live maintenance system to ensure all PICs and their staff teams in designated centres have real time oversight on maintenance requests and scheduled works to be completed.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
As part of the comprehensive action plan for Clannad staff team it was agreed with the PIC and PPIM to provide consistent On the Job mentoring (OJM) to the Clannad staff team over the next months regarding their understanding of person centred planning and meaningful days for people supported within their roles.

The Quality Manager commenced OJM on the 24/11/2021, visiting Clannad at least once a week to meet with staff members. The aim of the OJM is to build the understanding within the staff team regarding meaningful days in line with persons identified roles.

Whilst first actions re the identified issues in Regulation 13 had been discussed at the team meeting on the 02/12/2021 this will further be addressed at the team meeting on the 12/01/2022 using SPC Vision & Mission statement and guidance on person centred planning.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: - A fence has been erected by SPC maintenance team around the septic tank on the - 17.11.2021 and PIC completed risk assessment re same. 4-inch pipes were cut down and covered with a cowl vent. - Gutters and outside area of premises was cleaned by maintenance team. - Gap in the back garden/ditch has been fenced. - Damp area in bedroom was assessed by plumber and advised that the water stain was from a previous leak. Maintenance have primed and painted the ceiling. - Old leak in bathroom: timber will be replaced with cladding. - 1 press in kitchen and sitting room have been repaired. - Inside painting is scheduled for completion in January 2022 as per SPC maintenance plan. - A deep clean of Clannad had been completed over 2 days immediately after the inspection took place on the 16 and 17/11/2021. - Moss has been removed from the driveway in front of the premises with a power hose. - Removal of cob webs and dead flies on outside of the premises had been completed by the 17/11/2021. - Removal of moss on the roof of Clannad premises is scheduled for completion (subject to weather condition) for the second week of January 2022. As part of the change management plan Interim Director of Service, PPIM, PIC and Quality Manager are visiting Clannad on a daily and weekly basis to oversee the state of the premises and discuss involvement of people supported within their roles of homemakers to identify any further actions arising regarding their home.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: As part of the action plan the PIC has addressed risk management with the staff team in Clannad. Identified risks have been assessed, addressed and are now included in the risk register: - Hand sanitisers are now stored in the locked chemical press in Clannad - The gas cylinder has been moved in the garage, a sign put in place to ensure adequate storage at all times, a risk assessment and a SOP completed to guide staff team. - The nail at a wall in the bathroom has been removed. - Incidents and risk management are part of the agenda of monthly team meetings. Understanding of how to review and discuss risks, incidents, management and follow up on same will be discussed at the next team meeting on the 12/01/2022. - Building understanding of risk management as part of person centred planning and monthly reviews for people supported is being address through the weekly On the Job mentoring with staff members.	

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Following actions have been completed since the inspection took place:
- A deep clean of Clannad had been completed over 2 days immediately after the inspection took place on the 16 and 17/11/2021.
- PIC and PPIM have reviewed the cleaning schedule for Clannad. It was identified that no changes were needed to the cleaning schedule but oversight of completion of cleaning and signing off on same.
- The vehicle was cleaned immediately after the inspection took place. The PIC also highlighted the importance of staff's responsibility to clean the house vehicle during Quality Conversations.
- PIC is addressing night shift duties and completion of cleaning during those shifts.
- Weekly cleaning of vehicle set as a reminder in house diary and followed through by staff member as delegated duty. Checked through visual checks and at Quality Conversations.
- As part of the change management plan Interim Director of Service, PPIM, PIC and Quality Manager are visiting Clannad on a daily and weekly basis to oversee the cleanliness of the house and address any issues immediately with the staff members present, sign the cleaning schedules and leave comments and actions as needed.
- Cleaning duties and Infection Prevention Control has been discussed on a daily basis with staff members since the inspection took place, at the team meeting on the 02/12/2021 and will also be highlighted again at the team meeting on the 06/01/2022.
- Health & Safety Department is issuing regular emails to all employees and notices via weekly SPC Bulletin regarding IPC.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The gas cylinder has been moved in the garage, a sign put in place to ensure adequate storage at all times, a risk assessment and a SOP completed to guide staff team.

All hand gel has been removed from hot press and is now stored in the locked chemical press in Clannad. H & S department also sent an email to all SPC houses to advise of appropriate storage of hand gel in houses immediately after the inspection too place.

A review of PEEPs and CEEP took place on the 16/11/2021. The PIC observed also a

simulated drill on 16/11/2021 at 12 noon. All people supported evacuated mobile. Duvet evacuation has been removed from the PEEP and all PEEPs are now reflecting the adequate evacuation procedure for people living in Clannad. This has also been discussed at the team meeting on the 02/12/2021 with the staff team. The PIC has also scheduled a night time simulated fire drill to be completed before 05/01/2022 to observe evacuation and support staff team through feedback.
Visit of fire officer has been completed on 04/11/2021. Information of same made available by PIC in fire folder to all staff members.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
As part of the comprehensive action plan for Clannad staff team it was agreed with the PIC and PPIM to provide consistent On the Job mentoring (OJM) to the Clannad staff team over the next months regarding their understanding of person centred planning and meaningful days for people supported within their roles.

The Quality Manager commenced OJM on the 24/11/2021, visiting Clannad at least once a week to meet with staff members. The aim of the OJM is to build the understanding within the staff team regarding meaningful days in line with persons identified roles. Whilst first actions re the identified issues in Regulation 13 had been discussed at the team meeting on the 02/12/2021 this will further be addressed at the team meeting on the 12/01/2022 using SPC Vision & Mission statement and guidance on person centred planning.

The Quality Manager is supporting the PIC in building capacity within her staff team. The Social Care Worker has been assigned to oversee monthly reviews and progression of roles for people supported.
To ensure monthly reviews are completed in line with SPC Personal Planning Framework and also build understanding within the team how to complete the reviews, ensure connectivity of all person's relevant information (e.g. risk management, financial plans, medical needs, etc.) monthly reviews have scheduled for completion between the 20/12/2021 and 06/01/2022.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

SPC Medication officer completed a file review for all people living in Clannad to identify any outstanding medical needs. Actions have been identified and were discussed as part of the regular action plan meetings. All outstanding actions have now been completed.

The annual medical review for one person supported was completed on the 18/11/2021. This is now reflected on the person's medical data sheet.
A referral for one person supported to Speech and Language therapist had been followed through and the review of persons swallow care plan took place on 08/12/2021. All recommendations are now reflected in the persons support plan.

As part of building understanding within the staff team regarding Personal Planning Framework and completion of monthly reviews, medical needs will be discussed at the next scheduled monthly review meetings on the 20/12/2021 and on the 04/01/2022, 05/01/2022 and 06/01/2022. Chiropody needs for people supported in Clannad will be part of this review and documentation of appointments will be discussed as part of the reviews.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Following actions have been taken since the inspection took place:

- SPC Behaviour Support Specialist met with the staff team on the 30/11/2021, compiled a list of recommendations regarding significant behaviours, more specific risk assessments and support plans and completed a full review of behaviour support documentation in Clannad.
- On the Job Mentoring available for staff team regarding significant behaviours
- Behaviour Support Specialist met with the PIC on 09/12/2021 and the developed action plan is followed through by the PPIM with the PIC. Following actions have been agreed between PIC and Behaviour Support Specialist:
- Consistent support/staff supervision for two people supported while in their home
- Staff to complete additional training as required i.e Personal Planning Framework, MAPA, Low Arousal/PBS
- More person specific detail in risk assessments & SOP's, especially in areas of behaviours of concern/distress etc. (i.e triggers/precursors/distractors etc)
- Update of Behaviour Support documentation
- Discussion of use of significant behaviour logs for any behaviour that is needed to be recorded and not considered an incident.
- Blank ABC's & Significant Behaviour recordings to be placed into each person supported's folder for accessibility for staff.
- Addition of safeguarding pathway to the safeguarding section of each person supported's folder.
- Archive outdated Behaviour support documents.

- The PIC completed an internal notification and monitoring notification for an incident discussed at the inspection.
- PIC and PPIM to contact Psychologist regarding relationship training for people supported and staff in Clannad, which could also include a compatibility assessment. Referral has been sent, PIC awaiting confirmation of date.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC and PPIM discussed approach to residents rights, privacy and dignity with staff team at team meeting on the 02/12/2021. Options of e.g. window contacts to be explored with person supported. PIC has sent a referral to the Psychologist regarding the exploration of a desensitisation program for this person supported re a possible trial of blinds or contacts on his bedroom window.
The staff team are currently trialing frosted contact on the person's bedroom windows and will observe and feedback. A daily log is currently being used to offer the person the option of using window blinds in the bedroom. A support plan and risk assessment have been developed. Exploration of same will be discussed further through person's monthly review meeting and at the next team meeting on the 06/01/2022.

The PIC and PPIM to further discussion with the staff team a person's private ensuite bathroom and how to support another person living in Clannad to respect this private ensuite. It was discussed to support one person in skills development regarding accessing her own ensuite bathroom and using a thumb turn lock on the bathroom door, which will provide protection to her own space. A support and skills teaching plan to be discussed with the other person supported to respect the person's own private ensuite bathroom. This will be further explored at the next governance meeting between PIC and PPIM in early January 2022.

Further support for PIC and staff team regarding reflection on person centred approach is being facilitated through On the Job Mentoring on a weekly basis.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	06/01/2022
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	06/01/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development	Substantially Compliant	Yellow	19/01/2022

	programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	17/11/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	17/11/2021
Regulation 23(1)(c)	The registered provider shall 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.	Not Compliant	Orange	06/01/2022
Regulation 26(2)	The registered	Not Compliant	Orange	30/11/2021

	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.			
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	17/12/2021
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	20/11/2021
Regulation	The registered	Substantially	Yellow	06/11/2021

28(4)(b)	provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Compliant		
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	20/12/2021
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	20/12/2021

Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	08/12/2021
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	08/12/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	09/12/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	20/12/2021