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:	Kilfane House
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	01 December 2021
Centre ID:	OSV-0007863
Fieldwork ID:	MON-0030626

About the designated centre

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

Kilfane House is a large purpose built bungalow located in a rural town in Co. Kilkenny, within easy access to local amenities. This centre acts as a platform for community access to Kilkenny City. Kilfane House provides community based living, in a home from home environment for four female adults with severe and profound intellectual disability and complex needs. The house consists of a kitchen/dining/living room, utility room, visitor's room, four bedrooms, a bathroom, accessible WC/shower room, two equipment store rooms and two small store rooms. Some of the residents use wheelchairs accessing the community. This is a high support centre, with a requirement for two staff during the day with a third to assist in accessing the community. There is one staff on night duty. The core staffing consists of a combination of a qualified person in charge and team leader/nurse, nurses, social care workers and health care assistants. The centre is a seven day residence open all year with no closure.

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 - 2015 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
Wednesday 1 December 2021	9:00 am to 5:00 pm	Sarah Mockler	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the four residents that lived in this designated centre. To gather a sense of what it was like to live in the centre, the inspector spent short periods of time observing residents as they completed their daily routines, speaking with staff and completing documentation review. Overall the impression was that residents overall received a good level of care and support and they were comfortable in their home. Improvements were required across a number of regulations to ensure a quality based service could be maintained on a continual basis.

As the inspection was completed during the COVID-19 pandemic, the time spent with the residents and staff in the designated centre, was done in line with public health advice. The inspector adhered to national best practice and guidance with respect to infection prevention and control, throughout the inspection.

On arrival at the centre, it was noted to be a newly built bungalow located near a small town in Co. Kilkenny.The home was well maintained, decorated in a homely manner with Christmas decorations on display, and very clean. Residents all had individual bedrooms which had been decorated to their individual taste. Residents had access to two accessible bathrooms. There was a large bright open plan sitting and kitchen area that lead onto a nicely kept garden area. There was a separate office space that was used also as a visitors room, if residents so wished.

On arrival at the centre in the morning, the residents were completing their morning routine with staff. Residents were observed to be supported in a caring manner across different aspects of care, such as support when mobilising and completing meal time routines. Staff spoke with residents in a kind and respectful manner. Residents appeared comfortable and were observed at times to smile towards staff as they were spoken too. Residents spent the morning time listening to music or looking through preferred magazines. Staff supported them with household chores such as laundry. Residents were observed to ask for help and support, with staff responding in a timely manner.

A milestone birthday for one of the residents was occurring on the day of inspection. Residents and staff had planned for the day which included decorating the house for this event and getting themselves ready for the upcoming celebration. They had spent the previous day buying the balloons and decorations for this day. The resident seemed excited when spoken to about their birthday and were eager to celebrate this event. Throughout the day staff came to visit the resident and brought presents and good wishes to the resident. Family members visited the resident later in the day to celebrate and share cake. All residents sat around the table with family members and staff and shared cake and tea. Staff and family members were heard chatting with residents throughout this time. There was a lovely relaxed atmosphere noted. All residents seemed comfortable in each other

presence

Staff spoken to expressed that residents were happy in their home, they were well settled and had adapted well following their transition to the new home. All residents moved in together in October 2020 from another designated centre from within the organisation. Respectful, dignified and caring language was used when staff spoke about residents. Staff were aware of their role to keep residents safe and provided good care that was in line with their assessed needs.

Documentation review indicated that residents enjoyed a variety of activities such as baking, shopping, family visits, attending day service, gardening, and day trips. Family and friend connections were important to the residents and contact was encouraged and supported.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

This was the second inspection of this centre since it had been registered. The findings of this inspection indicated that residents enjoyed a good level of care and support. The registered provider and staff team were striving to ensure a quality based service was provided and that residents were kept safe. In order to maintain this level of quality a number of improvements were noted across some regulations, including staffing, supervision and access to some training. Overall, although systems were in place to ensure the service was appropriately monitored, further oversight was required to ensure quality improvement could be continually developed.

There was a clear management structure in place in the centre. The person in charge was present on the day of the inspection and the community services manager, who participated in the management of this centre, also met briefly with the inspector. The person in charge occupied a full time role and had remit over two other centres at the time of this inspection. The inspector found that they strived to maintain a strong presence in this centre, however, due to different presenting circumstances the person in charge had been required to spend a large proportion of their time in one of their other designated centre over recent months. The area manager had commenced in their role a couple of weeks prior to the inspection also.

The registered provider had developed an audit schedule to ensure that a range of areas of service provision were monitored. On review of this system it was found not be be consistently implemented. An annual review report was not available on the day of inspection. The person in charge discussed that this process had recently commenced. Six monthly provider unannounced visits had occurred within the relevant time frames. Other audits such as finance, cleaning, fire, and health and

safety audits were not occurring in line with the organisations stated time lines. For example, health and safety monthly checklists had not been completed since May 2021.

There was no overarching quality improvement plan available to review in line with audits that had been completed. Although some audits had quality improvement plans available, there was no overarching tracking system to ensure all actions were been completed on a timely basis. For example, a hygiene audit in May 2021 identified the need for pedal bins, this had not been added to a quality improvement plan and this issue remained outstanding on the inspection day.

On the day of inspection there were three whole time equivalent vacancies in the staffing team. The impact of these vacancies was discussed, including that at times, residents access to the community was impacted due to the number of staff available. In addition to this staff vacancies had resulted in the use of unfamiliar agency staff. Despite the agency staff completing a short induction procedure and on call management available for support, they had failed to deliver on some basic care needs for residents during their shift.

For the most part, staff were were facilitated and supported to receive up to date training including refresher training to ensure adherence to best practice. There was no evidence if one agency staff member had completed one particular training to deliver care in line with a resident's specific assessed need. In addition to this supervision, known as quality conversations was not occurring in line with the organisations policy.

Regulation 15: Staffing

Although the registered provider was making considerable efforts to recruit staff, there were three whole time equivalent staff vacancies on the day of inspection. This was equal to a third of the current staff team. For the most part staffing levels were available to ensure residents needs were met and that they were well cared for within the home. The optimal level of having three staff available during the was not always possible. This at times had impacted residents ability to access the community.

In addition to this, agency staff were being utlised to cover staff absences. Recently an agency staff had to cover an overnight shift which required them to be lone working. Although systems were in place to support the staff member during this time, they had failed to deliver care that was in line with residents' specific assessed needs.

Judgment: Not compliant

Regulation 16: Training and staff development

For the most part, staff had completed training and refresher training in line with the organisation's policies and procedures, and the residents' assessed needs. One agency staff had not completed training in line with a resident's specific assessed need.

The staff team were not in receipt of regular formal staff supervision. Formal staff supervision was known as quality conversations, and the provider had policies in place to indicate that it should occur minimally once per quarter. Aspects of the staff work, including action plan updates, supports required, delegated duties, keyworking duties and any other work related issues were topics covered during these meetings. On review of these records there were a number of gaps in relation to staff receiving supervision in line with the stated policy. Some staff had only received formal supervision once in the calendar year.

Judgment: Not compliant

Regulation 23: Governance and management

Although there were management systems in place such as audits, team meetings and staff supervision, they were not effective in ensuring comprehensive oversight at all times.

There was no annual review report of the quality of care and support provided in the centre. Audits were not occurring within stated time lines. There was no overarching system in place to ensure actions were being addressed once identified from audits

Team meeting meetings not occurring on a regular basis.

A familiar staff team in place allowed good care to be provided to residents, however, the absence of comprehensive systems for oversight meant that areas of improvement in service delivery were not always identified or implemented.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of accident and incident reports in the centre and found that the Chief Inspector was notified of the required incidents in line with the

requirement of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

On the day of inspection there were no open complaints. There was a system in place for recording and logging complaints. Staff spoken with familiar with the process and identified the need of this system to drive quality improvement.

Judgment: Compliant

Quality and safety

Overall residents lived in a warm, clean and comfortable home. A review of documentation and observations indicated that residents received a good level of care when familiar staff were in place. Residents had settled into their new home and the provider was striving to ensure residents had a meaningful life. Improvements were required in relation to the management of risk, residents' personal planning documentation, infection prevention and control measures and written evacuation procedures.

The centre was a new build specifically designed to accommodate the four residents. All residents transitioned to the home in October 2020. The premises was found to be well maintained and presented throughout. Residents' bedrooms were personalised and nicely decorated and the centre was bright and spacious, with ample storage and appropriate cooking and laundry facilities for the residents living there. The centre was fully accessible throughout and some bedrooms and bathrooms had been equipped with overhead hoists.This provided for the possible future needs of residents and it was anticipated that this would ensure that residents would be able to remain in their home long term, should their mobility needs increase.

The inspector viewed a sample of individualised assessments and personal plans in place in the centre. Plans provided good information for staff about residents support needs. However, elements of the plan had not been updated an an annual basis which is the minimum requirement to ensure personal plans are kept reflective and up-to-date in line with residents' needs.

To ascertain social roles and goals the organisation implemented visioning meetings to establish the individuals unique interests and hobbies. A sample of these meeting notes were reviewed. A number of goals and roles were identified for each resident that was individual to their specific preferences. Two different documents were

utilised to track the residents' progress with these goals. It appeared unclear if the residents' progress with their personal goals was effectively evidenced due to this system.

Fire safety systems were in place in the centre, including a fire alarm system, a smoke detection system, emergency lighting and fire doors. There were records of daily checks completed by staff and at the start of each shift fire duties were assigned to the staff members on duty. Fire doors were held open by a specialised safety device that enabled the door to remain ajar and would close if the door was pulled or if the fire alarm system was activated. These had been devices had been adjusted to ensure that residents could safely and independently open and close their doors without compromising fire safety measures. This improvement had been made following findings from the previous inspection. Although individual personal evacuation plans were in place, they had not been updated in over a year. Some plans were not reflective of residents' current mobility needs.

Staff spoken to had knowledge of their responsibilities in the area of safeguarding and had completed appropriate training. Residents appeared comfortable in the presence of staff and staff were seen to speak to and support residents in a respectful manner. A recent incident that occurred in the centre had been appropriately managed, investigated and appropriate measures were put in place to ensure residents safety at all times.

Regulation 17: Premises

The designated centre was clean, adequately maintained and decorated in line with residents individual preferences and tastes. Photographs of residents were on display through the home.

The centre was homely, with large windows in place in communal areas that resulted in bright welcoming spaces for residents. Corridors were wide and adaptations had been made to ensure the premises was accessible to residents that required support with their mobility needs.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had put in place systems for the assessment, management and ongoing review of risk. A risk register was in place to provide for the ongoing identification, monitoring and review of risk. This required updating to ensure that all risks were identified and managed appropriately and that the information available to staff was accessible and accurate. For example some individual risk assessments had not been reviewed in over a year. In addition to this, following an

incident, a resident's risk assessment was not updated in a timely manner.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Overall the residents were protected by the infection prevention and control policies, procedures and practices in the centre.

The provider had developed contingency plans in relation to COVID-19. The premises was found to be clean during the inspection and there were cleaning schedules in place to ensure that every area of the house was being cleaned regularly.

There were stocks of PPE available. Staff had completed training in relation to infection prevention and control including hand hygiene and donning and doffing PPE.

Some minor improvements were required to ensure best practices in relation to infection control procedures were always adhered too. Appropriate waste management systems were required in the form of pedal bins in some areas of the home. The storage of incontinence products also required review to ensure they were stored in an area that did not compromise the integrity of the product.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety systems were in place in the centre, including a fire alarm system, a smoke detection system, emergency lighting and fire doors. There were records of daily checks completed by staff and at the start of each shift fire duties were assigned to the staff members on duty. Fire drills occurred at regular intervals.

Although each person had a personal evacuation plan in place, these plans had not been updated on annual basis. Some residents' mobility needs had changed and additional equipment was in place to assist these residents. The resident's plan had not been updated to reflect how the resident would use this equipment in the event of an emergency.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A sample of residents' personal plans were reviewed. These plans contained an assessment of health, social and daily living needs which informed care plans to guide staff on how to best meet residents' assessed needs. Some care plans had not been updated or reviewed on an annual basis, so it was unclear if they had the required information in relation to meeting residents' specific needs.

Although there were systems in place to monitor the effectiveness of personal goals as identified in the annual visioning meeting, gaps in the documentation made it unclear if these goals were being implemented and monitored on a consistent basis. For example some goals identified for one resident had no information in relation to their progress since June 2021.

Judgment: Substantially compliant

Regulation 6: Health care

The residents were being being supported to access good health care. They had their health care needs assessed and care plans were developed and reviewed as required.

Residents had access to health and social care professionals in line with their assessed needs and were found to be accessing national screening programmes in line with their wished, their age profile and their assessed needs.

Judgment: Compliant

Regulation 9: Residents' rights

Although for the most part, resident rights were upheld and respected. A historical practice of two hourly night checks required review to ensure it was best meeting the individual assessed needs of residents.

Judgment: Substantially compliant

Regulation 8: Protection

Arrangements were in place to ensure that residents were protected from all forms

of abuse. Throughout the inspection residents were seen to be comfortable in the presence of staff members. Staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. All staff had responded in an appropriate manner to a recent incident that occurred in the centre. Staff immediately reported the concern which subsequently resulted in timely investigations and ensured that safeguarding plans were put in place to ensure further incidents did not occur.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Safe management practices were reviewed and monitored in this centre. Medication was stored securely. Staff were trained in the safe administration of medication. A medication audit had recently been completed and had identified some practices that required review. This included the the use of maximum doses on PRN medicines (medicines only taken as the need arises) protocls.

On review of residents individual medicine management system, some aspects had not been signed or dated appropriately for one medication.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant

Compliance Plan for Kilfane House OSV-0007863

Inspection ID: MON-0030626

Date of inspection: 01/12/2021

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
One staff member has been redeployed from another SPC designated centre from the 10/01/2022 to reduce the current vacancies to 2 WTE.

Recruitment is ongoing across SPC and the PIC and PPIM will further discuss allocating new employees to Kilfane House. Overtime for SPC staff is offered and available.

• The efforts SPC recruitment are undergoing presently to reduce the current vacancies are as follows: Advertising and building online presence on all available sources i.e. Indeed, Active Link, LinkedIn, SPC website along with any available Facebook groups which attract our target audience.
• SPC have undergone routine local radio campaigns reaching out to audiences and listeners from KCLR FM, Beat FM & Tipp FM. SPC has also advertised on these radio's social media platform.
• SPC has routinely contacted the majority of all training providers, schools and colleges. Meetings were set up with Training providers particularly of Pre-Nursing Students and QQI Level 5 providers.
• SPC has networked with the ETB training boards.
• SPC Registered on https://www.europeanjobdays.eu European jobs portal as provided by Department of Health.
• SPC uses all Internal & External notifications of roles using local jobs boards also.
• Virtual and face top face jobs fares are used when it is feasible.

Saint Patricks Centre is currently trialling a Recruitment & Retention pilot project, which includes recruiting potential employees with varying work and life experiences matched with the broader requirements of the role. These employees will be supported to complete on the job training program and be supported by the 'buddying' model.

The PIC is availing of regular and familiar relief and agency staff to ensure staffing levels

meet the needs of the ladies supported in Kilfane House. The PIC can also avail of short term re-deployment from his two other designated centres in the case of emergency.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The agency staff member has completed the mandatory refresher training since the inspection took place.

All Training Dates for mandatory & house specific training for 2022 is on the Q Drive (in addition to being emailed to all Users email) for all employees to access and staff training is to be incorporated in Rosters accordingly. In respect of refresher courses, the Training Department sends reminders to employees, PICs & PPIMs to advise them of expiry dates and to provide available training dates.

Training and refresher training needs are discussed at the monthly team meetings.

The PIC has addressed the gaps in Quality Conversations and has put a plan in place to complete same by latest 30/01/2022. A schedule for completion of Quality Conversations for 2022 has been developed for Kilfane House.

Quality Conversations are also incorporated in the currently developed Compliance Manual to be presented at a Quality & Compliance Working Group session with middle and senior management on the 13/01/2022.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The outstanding annual unannounced visit has been started in Kilfane House since the inspection took place and will be completed by the 30/01/2022.

The PIC has addressed the gaps in Quality Conversations (QCs) with a plan in place for completion by latest 30/01/2022 of all outstanding QC's.
As part of the QCs with all staff members and the next team meeting on 12/01/2022 the PIC will further address delegated duties, completion of audits and follow through on

actions identified, team work between day and night shifts, employee's action plans.

On provider level the following steps are currently being taken to provider further support to all management and employees across the service and ensure good governance & oversight:
• Development of a Compliance Manual: Community Service Manager and Quality Manager are currently developing a manual based on each regulation, outlining SPC policies, processes, pathway, systems, audits in place relevant to each regulation. This manual will help employees to gain a better oversight and understanding on the systems to be followed within each regulation. A draft version of this manual will be presented at a quality and compliance working group session with middle and senior management on the 13/01/2022. PPIMs and PICs will avail of this manual to discuss delegation of duties with their staff teams.
• Full review of compliances/non-compliances from 2021 HIQA inspections and unannounced visits across SPC service will take place on the 13/01/2022 with the Senior Management Team and Community Service Manager to ensure all identified risk areas are discussed and addressed in a timely manner.
• A list of delegated duties for staff nurses and Social Care workers will be issued by the Quality Department to all PICs to further implement delegation and good practices of governance & management.
• SPC is further progressing on the development that all PICs will have responsibility for only 2 designated centres due to PICs returning from maternity leave and current recruitment.
• A workplan for absence of PICs has been implemented in 2021 across the service to ensure oversight and good management of designated centres during PIC absences and delegation of duties.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC and SCW are currently working on reviewing and updating the individual's risk assessments. This will be completed as part of each person's monthly review by the end of January 2022.
The PIC has identified the SCW to lead out on overseeing the ongoing review of monthly reviews for each person supported and include the review of risk management and risk assessments as part of the personal planning reviews. The SCW will provide On the Job mentoring within the team. Additionally, the staff nurse will provide support to the staff team regarding review and update of risk register and risk assessments.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The pedal bin has been put in place immediately after the inspection took place.
Incontinence products are now stored in the appropriate area in Kilfane House in a store room.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PEEPs have been updated since the inspection took place. The mobility needs of one of a person supported changed requiring the use of a walker and this piece of new equipment is now incorporated in the person's PEEP. The PIC will oversee a fire drill will be completed by latest 14/01/2022 to reflect how the person would use the equipment in the event of an emergency evacuation.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
On the Job mentoring is scheduled with the SCW in Kilfane for the 11/01/2022 to discuss further support needs in building understanding within the staff team regarding the Personal Planning Framework.
The SCW will be supporting the PIC and leading out on overseeing the completion of documentation to evidence progression of roles and goals.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The PIC will review night checks in Kilfane at the next team meeting on the 12/01/2022 to assess the individual requirements of night time checks for each person living in Kilfane House. Any changes will be reflected in person's risk assessments.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The PIC has added medication administration to the agenda for the next team meeting to ensure all staff adhere to safe practices in line with SPC policy.

The PIC is currently looking at a possible change of pharmacy due to an issue arising with the current pharmacy in the local community in relation to transcription issues regarding Kardex.
A pharmacy has been contacted and they can provide the service that we require. The staff team are currently sourcing the information required for changing pharmacy before the next month's supply of medication is received.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	10/01/2022
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 programme.	Substantially Compliant	Yellow	30/01/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/01/2022

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.	Substantially Compliant	Yellow	13/01/2022
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	30/01/2022
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.	Substantially Compliant	Yellow	30/01/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by	Substantially Compliant	Yellow	02/12/2021

	adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(4)(b)	The registered 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.	Substantially Compliant	Yellow	14/01/2022
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	20/01/2022

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.	Substantially Compliant	Yellow	11/01/2022
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	11/01/2022
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	Substantially Compliant	Yellow	12/01/2022

	personal information.			