Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Clann Mór 2
Name of provider:	Clann Mór Residential and Respite Company Limited by Guarantee
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	28 and 29 November 2022
Centre ID:	OSV-0004929
Fieldwork ID:	MON-0037011

About the designated centre

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

This service comprises of three community houses located in Co. Meath. It provides care and support to nine adults with intellectual disabilities. Two of the houses are terraced bungalows located within a short walk of each other. These bungalows consist of a large sitting room, a kitchen cum dining room, three bedrooms (one being en-suite) and a large communal bathroom. Each resident has their own bedroom, which are decorated to their individual style and preference. The other house is a large detached two-story bungalow located approximately 25 kilometres away. This house comprises of a large fully furnished sitting room, a kitchen cum dining room, five bedrooms (three downstairs and two upstairs) and a communal bathroom on each floor. There are private well maintained garden areas to the front and the rear of the property, with adequate private and on-street parking available. The house is staffed by the person in charge, community facilitators and community based support staff. The aim of the centre is to enable people with disabilities to live meaningful lives of their choosing in their local communities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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 28 November 2022	09:45hrs to 16:30hrs	Sarah Cronin	Lead
Tuesday 29 November 2022	10:00hrs to 15:30hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This unannounced inspection took place to monitor regulatory compliance. The inspection took place over two days, and the inspector visited each of the three houses in the designated centre and spoke with eight of the nine residents living there. The inspection found that for the most part, residents were in receipt of good day-to-day care and lived in nice homes. They were well presented and reported to be comfortable and content in their homes. However, there were poor levels of compliance with many of the regulations inspected. Areas which required improvement included governance and management, risk management, safeguarding and protection against infection. These are described in detail in the body of the report. Due to concerns relating to the oversight and monitoring of care and support and the potential risks for residents associated with this, a cautionary meeting was scheduled with the provider after the inspection.

The first house which the inspector visited is based in a housing estate outside a large town in Co. Meath. The house is a large detached dormer bungalow and is home to four residents. Downstairs comprises three resident bedrooms, two bathrooms, a kitchen and a sitting room. There was a staff desk space located under the stairs. Upstairs is a staff sleepover room and office , another bathroom and a bedroom. There was a large garden to the rear of the property. The house was found to be well suited to residents' needs and rooms were reflective of residents' interests and personal histories. They had ample room to store their belongings. The laundry room in the house was accessed through the garden and required refurbishment of the flooring and walls. There were photographs of residents enjoying different activities throughout the house. There was a friendly and homely atmosphere in the house, with residents sitting chatting together after returning from their day service. Residents were playing bingo and having a cup of tea with staff before preparing the evening meal. Residents told the inspector about taking turns to cook each night and helping out with chores. They told the inspector that they enjoyed living in the house together and that they all got along well.

The second and third homes were in a neighbouring town and both houses were on the same road in a housing estate. The houses were both bungalows and comprised a sitting room with an office space, a kitchen, one bedroom with an en-suite, two further bedrooms and a large bathroom. Both properties had gardens to the rear. These houses were found to be in a very good state of repair and well suited to residents' needs. Residents talked about living in the centre and all reported to be happy in the centre. Residents spoke about their plans for an upcoming Christmas party. Residents told the inspector that they had regular meetings and that they felt safe in their homes. They told the inspector who they would speak with if they had any concerns about their support.

Residents were consulted with and participated in the running of their home in a number of ways. House meetings took place on a regular basis and there was a set agenda in place. The provider held advocacy committees meetings up to eight times

a year and each house was represented at that forum. Some residents were part of the HR interview processes where appropriate. The provider held a residents training , information sharing and collaborative forum where a topic of interest is explored and external speakers were invited. Recent workshops had included working on the theme of respect, on medication and on COVID-19. There was evidence to indicate that residents were well supported to maintain relationships with family members and people who were important to them.

Residents in the centre attended day services between two and five days a week in the vicinity and many used a local transport bus to get there each day. They enjoyed activities such as arts and crafts, attending a local arch club and using local amenities. Residents told the inspector they enjoyed living in the house and described staff as "very good". Another resident told the inspector that they felt "blessed" to live there, while another noted that they "get all the support they need". The inspector viewed feedback which some family members had given in relation to the services. Families were largely satisfied with the service , with one family saying "it's everything you want from a service". Family forums were held by the provider throughout the year.

Residents goals for their person-centred plans required review to ensure that they were appropriate to residents and that they were progressed in a timely manner. For example, one resident wished to work on administering their medication, there was no evidence to indicate that the goal was not progressed. While residents were attending day services, activity planners did not indicate many more activities to ensure residents progressed towards completing their goals. For example, for one resident the planner was not completed for ten days out of a month prior to the inspection, while for another a week was left entirely blank. Another resident had ten days over a three week period with no activities documented on their planner and a fourth resident had only three entries out of twenty one. Due to this gap in documentation, this did not provide evidence and therefore assurances that residents' person-centred plans were appropriate to their needs and ensure goals and activities were progressed.

In summary, residents in this designated centre were found to be living in nice homes which were suitable for their assessed needs. Residents whom the inspector met reported to be happy and content in their homes. They were all well presented and appeared comfortable in the company of both the management and the staff. Interactions over the two days were noted to be kind and friendly. Staff were knowledgeable about residents' needs and preferences. However, there were poor levels of compliance with many of the regulations found and these are detailed below. The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre and how these arrangements affected the quality and safety of care being delivered.

Capacity and capability

The inspector found that the governance and management arrangements for the centre were not adequate to oversee and monitor the services provided to residents to ensure they were receiving safe, good quality care. Since the last inspection of the centre, a person in charge had been appointed to the centre. They reported to the service manager and in turn, to the Director of Services. The person in charge had responsibility for the day-to-day management of the designated centre and were supported in their role by community facilitators and community based support staff. They were based in the provider's main office and visited each house once a week at a minimum. They were also available by phone to residents each day.

The provider had a number of quality assurance measures in place. However, these were not self-identifying areas for improvement or ensuring that actions were completed in a timely manner. The inspector viewed the two most recent six-monthly unannounced provider visits. These had been carried out by another person in charge within the organisation and had consisted of visiting one house for each visit. The results of these visits were recorded on a spreadsheet. Without a written report, it was unclear how judgments had been made and what the exact findings were. The most recent annual review was also viewed by the inspector. This did not have the voice of the resident or their representatives included, as required by the regulations. The written report was not suitably detailed and therefore did not provide suitable assurances on oversight of the quality and safety of care of residents.

The centre was resourced with an appropriate number of staff who had the required skills to ensure that residents' assessed needs were met and supported. Planned and actual rosters were well maintained. It was clear that the provider was endeavouring to ensure continuity of care to residents by using a panel of regular relief staff.

Staff training required improvement. While staff had completed courses in safeguarding, manual handling, medication and infection prevention and control (IPC). Gaps were identified in areas such as positive behaviour support, diabetes and insulin and first aid. Some areas of need in residents' assessments of need such as requiring a modified diet had not been identified as a training need. Staff supervision took place three times per year in addition to a performance management conversation. A supervision structure was also in place for relief staff.

The provider had a policy on admissions and contract for the provision of services. Contracts of care referred to residents having a financial assessment carried out to inform the fee they would pay. Assessments required review to ensure that there was clarity and equity on the amount of disposable income residents had left each week after paying their fee. This regulation had a level of non compliance on previous inspections in the organisation, and in this specific centre in 2018.

Regulation 15: Staffing

The centre was resourced with an appropriate number of staff who had the required skills to ensure that residents' assessed needs were met and supported. Planned and actual rosters were well maintained. There was a vacancy in one of the houses and the provider had a panel of regular relief staff who had covered some shifts in the weeks prior to the inspection taking place. It was clear that the provider was endeavouring to ensure continuity of care to residents and had recently recruited a staff member who was due to commence in the weeks after the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training required improvement. Staff had all completed courses in safeguarding, manual handling, safe administration of medication, infection prevention and control and positive behaviour support. Staff had completed additional training such as accredited training in care of the elderly and Lámh training. However, there were gaps in training required for a number of staff. For example, five staff had not completed training on diabetes and insulin, three had not completed training in supporting residents with behaviour support needs while one staff member was out of date in their first aid. All of these were assessed areas of need for residents in the centre. Some areas of need in residents' assessments of need such as requiring a modified diet had not been identified as a training need.

Staff supervision took place twice per year in addition to a performance management conversation. A supervision structure was also in place for relief staff within the organisation.

Judgment: Substantially compliant

Regulation 23: Governance and management

As stated earlier, the inspector found that the governance and management arrangements for the centre were not adequate to oversee and monitor the services provided to residents to ensure they were receiving safe, good quality care. Since the last inspection of the centre, a person in charge had been appointed to the centre. They reported to the service manager and in turn, the Director of Services. The person in charge had oversight of this designated centre and were supported in their role by community facilitators and community based support staff. They were based in the provider's main office and visited each house once a week at a minimum.

The provider had a number of quality assurance measures in place including audits carried out by community facilitators and overseen by the person in charge.

However, these were not self-identifying areas for improvement or ensuring that actions were completed in a timely manner. The inspector viewed the two most recent six monthly unannounced provider visits. These had been carried out by another person in charge within the organisation and had consisted of visiting one house for each visit. This meant that each house was receiving an unannounced visit every eighteen months. The results of these visits were recorded on a spreadsheet. Without a written report, it was unclear how judgments had been made and what the exact findings of these had been. The most recent annual review was also viewed by the inspector. This did not have the voice of the resident or their representatives included, as required by the regulations. The written report was not suitably detailed and did therefore did not provide suitable assurances on oversight of the quality and safety of care of residents.

A number of meetings took place at local and senior management level. The persons in charge for the four centres in the organisation met with the Service Manager each week and this was used to review residents as required and to discuss service improvements and shared learning. A quality and safety meeting took place on a monthly basis. Staff meetings were held every two months. The agenda for these meetings had a set agenda. There was not clear evidence of sharing learning from any outbreaks, inspections, incidents or accidents, safeguarding concerns or fire drills on minutes viewed.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had a policy on admissions and contract for the provision of services. However, further clarity was required in relation to financial assessments and how these linked to residents' individual contracts of care. For example, all of the 5 contracts viewed by the inspector indicated that there was now a record of the conditions of service provision for both the resident and the provider. Contracts contained a clause indicating the average amount a resident would pay and noted that a financial assessment would be carried out to inform their individual fee. However, in spite of assessments being done, residents' files which the inspector reviewed noted that they all paid a set fee. This meant that for some residents, they were left with very little disposable income each week. This required review to ensure that there was clarity and equity on the amount of disposable income residents had left each week after paying their fee.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had submitted most notifiable events to the office of the Chief Inspector as required by the regulations. However, one incident of the use of a restrictive practice had not been notified to the Authority.

Judgment: Not compliant

Quality and safety

Residents' well being and welfare was maintained by a good standard of evidence-based care and support. It was clear that residents were supported and consulted with in relation to the running of their home. However, there were significant gaps in documentation relating to areas such as risk management, safeguarding, individualised assessments and personal plans and infection prevention and control.

Residents in the centre had assessments of need in place. However, these assessments were documented on initial admission to the centre and reviewed by the person in charge each year. It was unclear what changes had been made and what relevant professionals were involved in the assessments and the personal plan arising from this assessment. There was an annual review meeting which took place with day services, a family member, the resident and a HSE representative, but the inspector did not see evidence of discussions relating to the effectiveness of the personal plan or on the goals chosen. This was a repeated finding. As stated earlier in the report, some of the goals documented for residents were not progressed, while other required review. For example, one resident had a goal of wishing to administer their own medication but there was no documentation to reflect the status of this. There were large gaps in documentation to evidence activities undertaken by residents.

Residents were supported to enjoy best possible health in the centre. They had access to a local GP and a range of other health and social care professionals such as psychology, psychiatry, speech and language therapy, occupational therapy, physiotherapy and dietetics. Many of these services were provided through residents' day services. There was evidence of discussions with residents about their end-of-life care preferences and residents accessed National Screening Programmes such as BreastCheck where they were eligible to do so.

Many of the residents in the centre presented with support needs in the areas of behaviour and mental health. Plans viewed by the inspector indicated that they had been developed by staff and they were not adequately detailed to guide staff practice, in particular in the proactive strategies which staff were able to take to minimise any escalation of incidents.

Safeguarding arrangements in the centre required improvement to ensure that all control measures outlined in safeguarding plans were enacted by staff. All staff members had been trained in safeguarding and were familiar with how to identify and report abuse. Where incidents occured, these were identified, reported and

investigated in a timely manner in line with national policy. However, for two incidents viewed, the required practices from staff in relation to recording that particular checks had occurred or that protocols relating to finances were followed were not consistently implemented.

As outlined earlier in the report, the centre comprises three houses which for the most part were found to be lovely houses and in a good state of repair. However, the laundry room in one of the houses was found to be in poor condition and required refurbishment.

The provider had systems in place in relation to the identification, assessment and management of risk. There was a system in place for reporting adverse events including a system for emergencies.However, this required improvement to ensure that all relevant risks were identified on the register, that they were relevant at the current time and that there were suitable arrangements in place to ensure monitoring and oversight of all risks in the centre. IPC risks were not all identified on the register. This was a repeated finding from a previous inspection in 2021.

The provider had implemented systems to protect residents from healthcare-associated infections in the centre. There was an IPC policy in place, but this did not contain adequate detail to guide staff practices in relation to management of contaminated linen and the management of body fluid spillages or blood. Both of these were particular risks in the centre. Contingency plans were not suitably detailed and there was not a clear review of the outbreaks which had taken place. There was not evidence of arrangements to ensure sustainable and safe delivery of antimicrobial stewardship.

The provider had suitable fire management systems in place. Detection and containment equipment, fire fighting equipment and emergency lighting were in each house. Regular checks took place and were documented. Residents had personal emergency evacuation plans in place. Fire drills had improved following a recent inspection of another centre. Drills now included scenarios and included identifying learning to take place.

Medication management was the responsibility of all staff. Staff were suitably trained in medication management. There were a number of medication errors in the centre in 2022. These were followed up on and the provider had a clear system in place to ensure ongoing supervision and further training of staff as required. There were appropriate systems in place for the prescribing, ordering, receipt and storage of medications. There was not adequate information available on the medications which residents were on in the centre, as required by the regulations.

Regulation 17: Premises

As outlined earlier in the report, the designated centre comprises three properties. All of the houses were found to be very clean and tastefully decorated in line with residents' needs and preferences. For the most part, houses were well maintained.

However, in one of the houses, the external laundry room was in a poor state of repair. The floor was stained and paint was peeling off the roof and walls.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place which met regulatory requirements. Risk management procedures and oversight of risk required review to ensure the timely identification, assessment and management of risk across all houses in the designated centre. Each house had a separate risk register and residents had their own risk assessments on file. These were regularly reviewed. However, the risk registers did not contain some risks identified in the provider's safety statement, nor did they contain some significant risks relating to infection prevention and control. Risk assessments required review to ensure that they were relevant and reflective of residents' current needs. The provider had a system for responding to adverse events including in the event of an emergency. Risk management had a level of non compliance on the centre's last inspection.

Judgment: Not compliant

Regulation 27: Protection against infection

The inspector found that the registered provider had put a number of measures in place to ensure that residents were protected from healthcare-associated infections. There was an IPC policy in place, which had been updated for staff members. However, it was largely focussed on COVID-19 and required further detail to ensure that there were suitable arrangements in place regarding antimicrobial stewardship, to ensure that IPC risks were identified and that staff were given clear protocols to follow in relation to cleaning and disinfection, the management of linen, the management of blood and body fluid spillages and the management of clinical waste. The contingency plan in place for each of the houses did not contain enough detail in relation to assigning zones of a centre where there was a positive case, stations and procedures relating to the donning, doffing and safe disposal of PPE in addition to specific information relating to residents' support needs and how best to meet those in the event that resident was required to isolate. The HIQA Self-Assessment tool had not been reviewed within the 12 week time line required which meant that IPC systems had not been reviewed to ensure they were reflective of current public health guidance.

All staff had responsibility for IPC in the centre, but there was not any IPC lead within the centre. Laundry in two of the three houses were done in a washing machine in the kitchen. However, contaminated laundry was something which

regularly occured in one of the homes and these houses did not have access to water soluble bags. Cleaning was the responsibility of staff and there were checklists in place for staff to follow. Touch points were done twice daily and this increased during a suspected or positive case of infection. However, logs did not contain cleaning equipment. Safety data sheets for chemicals used in each house were not available to view. The centre had experienced two outbreaks in the past year. There was evidence of the person in charge linking with public health during these events. However, there was not a documented review of the outbreaks or identified learning.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had put suitable fire safety measures in place. All houses had fire doors, fire fighting equipment, alarms and emergency lighting in place. These were checked regularly to ensure they remained in good working order. Servicing and maintenance was carried out by an external agency as required. Each resident had a personal emergency evacuation plan in place. Documentation of drills had improved following a recent inspection in another centre. Drills now contained scenarios and details of actions taken to identify and action any areas required.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had suitable arrangements in place in relation to the ordering, storage, prescription and administration of medication. There had been a number of medication errors over the previous months. The provider had a clear system in place to respond to these incidents, which included one-to-one debriefing and re-assessment and training where required. Prescriptions were sent directly from the GP to the Pharmacy via a secure online system. In line with temporary legislation, these prescriptions were on file and did not have signatures on them. However, there was very little information available on the specific medications which residents were on in each house, as required by the regulations.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents in the centre had assessments of need in place. However, these assessments were documented on initial admission to the centre and reviewed by the person in charge each year. It was unclear what changes had been made and what relevant professionals were involved in the assessments and the personal plan arising from this assessment. There was an annual review which took place with day services, a family member, the resident and a HSE representative, but the inspector did not see evidence of discussions relating to the effectiveness of the personal plan or on the goals chosen. This was a previous finding on inspection in 2020.

Residents goals for their person centred plans required review to ensure that they were of good quality and that they were progressed in a timely manner. For example, one resident wished to work on administering their medication, there was no evidence to indicate that the goal was not progressed. While residents were attending day services, activity planners did not indicate many more activities to ensure residents progressed towards completing their goals. For example, for one resident the planner was not completed for ten days out of a month prior to the inspection, while for another a week was left entirely blank. Another resident had ten days over a three week period with no activities documented on their planner and a fourth resident had only three entries out of twenty one. Due to these gap in documentation, the inspector was not assured that residents' person-centred plans were appropriate to their needs and ensure goals and activities were progressed. These gaps were not identified by the provider on the audits viewed.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to have best possible health in the centre. They had access to a GP and psychologist within the service in addition to having nursing support where required. Residents also accessed occupational therapy, speech and language therapy, physiotherapy and dietetics where required. There was evidence of discussions with residents relating to their end-of-life care preferences and their wishes in relation to resuscitation. Residents had access to National Screening Programmes such as BreastCheck where they were eligible.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who had behaviour support needs had plans in place. It was unclear who was responsible for developing and maintaining these plans. For example, some plans had been developed a number of years ago and reviewed by staff members on an annual basis. Some residents had input from a clinical psychologist and these

notes were kept separately to the positive behaviour support plan. As such , it was unclear who was responsible for the development of plans and whether they were reflective of and appropriate to residents' current needs. Some of the plans were not detailed enough to guide staff practice. For example, plans had a list of triggers for residents and how to react and debrief but they did outline proactive strategies which would best support residents to have a good day. In addition to behaviour support plans, some residents had mental health plans which were similar and it was unclear which was best for staff to follow.

Judgment: Substantially compliant

Regulation 8: Protection

Oversight of safeguarding plans required improvement to ensure that measures outlined in safeguarding plans were followed by all staff. For one resident, a safeguarding plan had indicated the need to carry out daily checks with the resident and this required documentation. The inspector noted that this was not done in line with the plan and this had not been noted on audits.

The provider's safeguarding arrangements, particularly relating to residents' finances required improvement. Following a safeguarding incident, the provider had updated their policy relating to residents' finances. Extra measures were put in place such as management approval for the withdrawal of funds over a certain amount, receipts to be provided for residents , signatures on financial records and ensuring that the amount of money held for residents on-site was below a defined amount. However, the inspector noted a number of gaps in documentation on all of these areas. Therefore, the inspector was not suitably assured that the measures taken by the provider were being implemented and in turn that residents were safeguarded from financial abuse.

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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Clann Mór 2 OSV-0004929

Inspection ID: MON-0037011

Date of inspection: 29/11/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Where required, staff will receive training in the following areas: Diabetes and insulin, PBSP, First aid, and FEDS.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Six monthly unannounced inspections will involve visiting all houses in the designated Centre. The findings, actions and outcomes from this inspection will be recorded in the six-monthly report. The annual report will include the voice of the residents and family members. The annual report will have more detail, giving oversight of the quality and care of the residents. At the Annual AGM residents and family members will be offered a summary of the Annual Report. Staff house meetings and quality meetings will have the following items added to the agenda; 'outbreaks and major incidents'. Minutes of meetings will include clear evidence of shared learning from the above headings.	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: Contract of Care On induction to Clann Mór it is noted that there is a weekly contribution charge. The	

residents are aware and have agreed to the weekly contribution. Each resident has a financial assessment, where the contribution is deducted from their income and any other money the resident has is disposable income. The wording of the contract of care will be reviewed and clarified.

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: One quarterly notification regarding restrictive practice (in place for one day), which was not sent, has subsequently been sent.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: External laundry room in Ashbourne will be refurbished.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Clann Mór safety statement will be reviewed and updated. The statement will include risks relating to infection prevention and control. Risks identified in the safety statement will be reflected in the house risk register. All risk registers in Clann Mór will be reviewed and updated as required.	
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: Infection prevention policy will be reviewed and updated. The policy will expand on the clear protocols, arrangements, management of blood, body fluids, clinical waste etc. The contingency plan will be expanded to include isolation procedures and specific support needs. This policy will be printed and sent to houses with an accompanying memo. All staff will sign to say they have read this policy. The HIQA self-assessment tool will be reviewed every 12 weeks to reflect current public health guidance. Team Leader house audit will include a specific IPC section. Infection Prevention lead in Clann Mór 2 will be PIC. Contaminated laundry will be washed in water soluble bags. All houses will be supplied with these bags. A staff memo and policy update will be communicated to all staff.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: All residents have a 'my medication explained' sheet in their medication folder. All houses have an Irish Medicines Formulary book in place and staff use it for information on medication. All staff are trained in the use of IMF.	
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: Assessment of need will be enhanced to include professionals involved in the individual's care as appropriate. If the needs of a resident change, the visits to professional will be recorded in their assessment of need. All resident goals will be reviewed and updated to make them meaningful and relevant. Team Leader audits will include review of goals. Weekly goal sheets were created during Covid for use when residents were cocooning and not attending a day service. These will be replaced by weekly activity planners which will include goal activities. Goal paperwork will be reviewed and updated. Staff will receive training in goal planning.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: All PBSP's will be reviewed by Clann Mór psychologist. Notes from appointments with psychologist with be included in the persons PBSP. All residents mental health care plans will be reviewed and included in PBSP, where appropriate. All staff will receive training in PBSP.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Safeguarding plans will form part of the monthly audit carried out by Team Leaders in each house. Safeguarding will be a topic on the agenda for all house meetings. Resident finance policy will be reviewed, and procedures around excess money will be updated. Resident finances will be part of the house team meetings with staff going forward. Resident finances will form part of the next staff quarterly. Clann Mór accounts administrator will review Team Leader audits on a quarterly basis to	

identify potential discrepancies in residents accounts.

Safeguarding for resident identified in this inspection will be reviewed.

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 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	28/02/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	28/02/2023
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	Not Compliant	Orange	31/01/2023

	monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	31/01/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/12/2022
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate,	Not Compliant	Orange	31/01/2023

	the fees to be charged.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/01/2023
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	31/01/2023
Regulation 29(3)	The person in charge shall ensure that, where a pharmacist provides a record of a medication-related intervention in respect of a resident, such record is kept in a safe and accessible place in the	Substantially Compliant	Yellow	31/01/2023

	designated centre.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	30/11/2022
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	28/02/2023
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there	Substantially Compliant	Yellow	28/02/2023

	is a change in needs or circumstances, which review shall be multidisciplinary.			
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	31/01/2023
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	28/02/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/01/2023