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:	Kells Court
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	22 January 2020
Centre ID:	OSV-0001895
Fieldwork ID:	MON-0020898

About the designated centre

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

Kells Court is a residential centre located on a campus setting in Co. Kilkenny. The centre has the capacity to support twelve residents. The designated centre is currently undertaking a decongregation plan to support residents to transition to community based homes in the local community by September 2020. The premises consist of three individual units with private access to each. Residents are afforded private bedrooms and communal areas. Currently the service provides twenty four hour support to seven residents over the age of eighteen with an intellectual disability. The core staffing within the centre consists of social care workers and health care assistants with nursing care afforded as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
22 January 2020	10:00hrs to 16:00hrs	Laura O'Sullivan	Lead

Views of people who use the service

The inspector had the opportunity to meet with six of the residents currently residing within the designated centre. One resident had started their busy day and was out and about when the inspector arrived. The inspector first arrived to one of the units within the centre where two residents resided. One resident was just after their breakfast and was planning their day with their key worker. This resident was due to move to their new home the following week and spent the morning shopping to pick out a chair for their new bedroom and a wall bracket for their TV. The other resident had a lie in. Following breakfast and a shower this resident brought the inspector to their room and showed them their guitar. They were watching TV in the living room also. Residents engaged and communicated with the inspector throughout the morning whilst waiting for activation to commence in the afternoon.

Within another unit four residents resided. One resident had just returned from a visit home and was having a cup of tea at the kitchen table. One resident was sitting in the living room, as they became a bit upset when they first met the inspector, the inspector afforded them time and respected their choice not to interact at that time. At intervals during the day this resident did request to go for a walk, with no assistance for same provided by staff. Another resident was asleep in their individualised chair in the living room. The fourth resident was lying on their bed in their bedroom. Activation in this unit was observed to be minimal with a very quiet environment. Music was not turned on to enhance the atmosphere until after lunch.

Staff members did appear to have knowledge of the needs of service users, however residents were observed to be provided supports in an inconsistent manner, with domestic duties being prioritised over meaningful activities for the individuals. Some residents were observed to spend very long periods of time with limited interaction from staff and no participation in activities or social activation and engagement.

Capacity and capability

The inspector reviewed the capacity and capability of Kells Court and found a number of areas of non-compliance with the regulations. A lack of effective governance systems and lines of accountability of this service was evident. The required levels of managerial oversight, supervision and review were not found to be in place.

Whilst it is acknowledged the centre is currently partaking in a process of transition to community based homes, the lack of oversight at both centre and organisational level required further review to ensure the centre is operated in an effective

manner.

Whilst a suitably qualified and experienced person in charge had been appointed to the designated centre, due to their governance remit within the organisation they did not have the capacity to ensure effective governance systems were in place within the centre. The individual acknowledged that due to the constraints of their role they were unable to complete systems to ensure the centre was operated in an effective manner. One team leader had been appointed to assist in the oversight of one unit within the centre. Staff reported that there had been numerous changes to the management structure within the centre which led to frustrations in the changing of systems.

The registered provider had appointed a governance structure to the centre. The person in charge reported directly to a newly appointed person participating in management (PPIM) who in turn reported to the senior management team. However, there was no evidence of any intervention or participation in the centre from the PPIM or evidence of communication within the governance team. No clear lines of responsibility and accountability in terms of oversight and review were in place which resulted in non-adherence to an audit schedule which was in place organisationally.

At organisational level, an annual review of service provision had been completed in March 2019. Although this was a comprehensive review which identified a number of areas for improvement, no action plan had been developed to plan the implementation of the required changes. No person was identified as being responsible for their completion and the person in charge did not monitor the actions required. No six monthly unannounced visits had occurred within the centre as required by the regulations. At centre level monitoring systems were not consistently being implemented. Where an audit had been completed, for example in health and safety, due to the non-completion of an action plan and lack of oversight, actions remained unaddressed and recorded as 'ongoing' e.g. evacuation times not being recorded on the record.

The registered provider had allocated appropriate staffing levels to the centre in accordance to the assessed needs of residents. The centre did however, have a reliance on agency staff at times which resulted in an inconsistency in the continuity of care. Whilst an induction pack had been developed for agency staff on commencement of their shift if they were unfamiliar to the needs of residents, this was not found to be completed with staff on the day of inspection.

Up to date training records were not provided on the day of inspection despite being requested on a number of occasions. Differing records were present in two units of the centre. Records were requested to provide update information however, as these were not provided by the close of inspection it is unclear if staff had been provided with the required training including refresher training.

Within the organisational policy, formal staff supervisions were to be completed through quality conversations. These were not completed within this centre in a consistent manner. The person in charge reported that the role of completion of

these conversations lay with the team leader. However, as a team leader had not been appointed to all three units of the centre no alternative system had been operated to support staff and implement this supervision procedure.

Regulation 14: Persons in charge

Whilst a suitably qualified and experienced person in charge had been appointed to the designated centre, due to their governance remit within the organisation they did not have the capacity to ensure effective governance systems were in place within the centre.

Judgment: Not compliant

Regulation 15: Staffing

The registered provider had allocated appropriate staffing levels to the centre in accordance to the assessed needs of residents. The centre did however, have a reliance on agency staff at times which resulted in an inconsistency in the continuity of care.

Judgment: Substantially compliant

Regulation 16: Training and staff development

It was not evident that staff were provided within appropriate training including refresher training.

Measures were not in place to ensure staff were afforded with effective supervision.

Judgment: Not compliant

Regulation 23: Governance and management

Whilst a governance structure had been appointed to the centre this was not effective in its current format. This did not identify the lines of authority and accountability, specific roles and details of service provision.

Monitoring systems in place were ineffective to address areas for improvement and

to identify areas of concern. Whilst an annual review of service provision had been completed, due ot lack of oversight actions remained unaddressed.

No six monthly unannounced visit had been completed to the centre .

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had ensured the development and review of a statement of purpose including information as set out in schedule 1.

Judgment: Compliant

Quality and safety

The inspector reviewed the quality and safety of the service to be afforded to residents currently residing within Kells Court. The registered provider was currently partaking in a de-congregation plan to transition the seven residents within the centre to move to community based homes in the local community.

This centre presented as an institutional campus based setting with the premises in need of repair both internally and externally. Improvements were required in a number of areas to improve the quality of life of residents including participation in activities and ensuring the rights of the residents are respected at all times.

The registered provider had not ensured each resident was provided with appropriate care in accordance with their assessed needs and wishes. An inconsistent approach to participation in meaningful activities was evident throughout the inspection.

One resident received one to one supports and was out and about all day. Their interest in farming and all things agricultural was evident throughout their personal plan and personal living space. Another resident was supported to go shopping for their new home and joined their house mate for a social outing in the afternoon. Contrary to this, resident's in one unit were not observed to participate in any activities for the duration of the inspection. Long periods of time were spent sitting in a communal area. Records of activities participated in were not maintained, with daily and weekly planners not in place to guide staff on preferred activities for each individual.

The registered provided had not ensured the centre was operated in a manner which was respectful to the rights of the residents. One resident was observed on

numerous occasions to request staff to go for a walk or a drive; this was not supported as staff reported they had household duties to tend to. This resident was also observed to wait approximately ten minutes to receive personal/intimate care from staff despite continually requesting same. In another unit, household duties were observed to be prioritised in place of activation, communication and stimulation of residents.

The centre is currently in the process of de-congregation with three residents due to transition to their new community homes in the coming weeks. Two residents had comprehensive transitional plan in place which was regularly reviewed. They had been facilitated to visit their new home and were consulted with regard to purchasing of furniture and personal items. It was evident from review of documentation and speaking with staff that this transition was being completed from a multi-disciplinary approach to ensure a smooth and effective transition for residents. In contrast to this another resident, who was due to move to their new home, had no plan in place to support them during this transition. Staff were not aware of any transitional plan and reported to the person in charge on the day of inspection that the family were unaware of these details also. This required review to ensure the transition occurred in a safe manner.

A number of restrictive practices were in place within the centre including electronic fobbed access to the units, lap-belts on wheelchairs and restrictive clothing in place for some residents. A number of these restrictions were deemed by the provider to be historic in nature within documentation review. However, no review had been completed to determine the assessed need for the continual use of these restrictions. Individual rights plans had not been developed. Staff spoke of a reduction in restriction however this was not evident in records maintained on site. The behaviour support guidelines for one resident were reviewed as part of transitional plan. These were observed to be person centred and focused on the individuality of the resident. Staff were observed adhering to this plan and supporting the resident in an effective manner in this case.

Systems in place to ensure the safety of residents required review. Whilst fire fighting equipment was in place, monitored by staff and serviced by competent individuals, evacuation procedures required review. Evacuation drills did not document the length of time it took to safely evacuate the building. Also, differing scenarios including staffing levels and time of day had not been completed to ensure residents were aware of all procedures to adhere to.

Whilst a risk register had been developed for the centre this had not been reviewed in line with set time frames to ensure current control measures were effective in reducing the likelihood and impact of the risk. the register had not been reviewed since March 2019 despite a number of risk requiring three month review. The identified risk included falls, manual handing and epilepsy. No review of incidents or accidents within the centre had been implemented to ensure measures in place were effective. For example, all staff had not completed all required training which was set out as a current control measure within the risk register.

Regulation 13: General welfare and development

The registered provider had not ensured each residents was afforded with appropriate care in accordance with their assessed needs and wishes.
The registered provider had not provided residents with access to facilities for recreation, opportunities to participate in activities in accordance with their interests and to support to develop and maintain personal relationships and links in the wider community.

An inconsistent approach to participation in meaningful activities was evident throughout the inspection.

Judgment: Not compliant

Regulation 17: Premises

The design and layout of the premises did not meet the aim and objectives of the service. They were observed to be institutional in nature with an number of areas both internal and external in a poor state of repair.

Judgment: Not compliant

Regulation 25: Temporary absence, transition and discharge of residents

The person in charge had not ensured that a consistent approach was in place for residents when transitioning to their new home. This required review to ensure all residents were supported to transition in a safe effective manner to their new living arrangements in accordance with their wishes.

Judgment: Not compliant

Regulation 26: Risk management procedures

Improvements were required in the area of risk management to ensure systems in place for the assessment, management and ongoing review of risk including a system for responding to emergencies was effective. Whilst a risk register had been developed for the centre this had not been reviewed in line with set time frames to ensure current control measures were effective in reducing the likelihood and impact

of the risk.

Judgment: Not compliant

Regulation 28: Fire precautions

Overall, the registered provider had effective systems in place for the detection and containment of fire. Improvements were required to ensure that residents were aware of all procedures to adhere to in the event of an evacuation.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The person in charge has not ensured that all restrictive practices were utilised in the least restrictive manner and for the shortest duration necessary.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had ensured that where an alleged incident or suspicion of abuse had occurred, an investigation had been initiated internally within the organisation. Where safeguarding plans had been developed, arrangements were in place to ensure that these were adhered to at all times.

Clear guidance was available to staff to ensure personal and intimate care was afforded in a respectful and dignified manner.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provided had not ensured the centre was operated in a manner which was respectful to the rights of the residents. Residents were observed to spend long periods of time not participating in any form of activity .

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

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Kells Court OSV-0001895

Inspection ID: MON-0020898

Date of inspection: 22/01/2020

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Due to the ongoing de-congregation and three centres still operating on SPC campus, Senior Management and Operations Team of SPC have reviewed the management of not only the designated centre Kells Court, but also two other houses on SPC campus to ensure better oversight and management. The Assistant Director of Service is taking on the role as PPIM for Kells Court, Lissadell and Greenfields until fully de-congregation is finalised in 2020. Notification for the change of PPIM was submitted via HIQA portal on the 30/01/2020. A new full time PIC, working 5 days a week has been appointed to the designated centre Kells Court. The new PIC is familiar with the people supported in Kells Court from working previously on SPC campus and has been working as a PPIM and Team Leader in other designated centres in SPC. Notification for the change of PIC was submitted via HIQA portal on the 03/02/2020. A handover process has commenced on the 30/01/2020 is currently underway between the current PIC and the new PPIM. The new PIC is currently on annual leave and will be attending the handover meetings from the 02/03/2020 onwards.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: SPC is currently recruiting to ensure the reduction of agency staff within all designated centres. The last recruitment phase has identified a 39 hours staff member to commence	

work in Kells Court in the 17/02/2020.

The new designated centre Ceol will be opening on the 05/03/2020, one person supported will be moving from Kells Court 1 to Ceol.
Also the new designated centre Cumas will be opening on the 16/03/2020, one person supported will be moving from Kells Court 3 to Cumas.
After the 16/03/2020 three people supported will be living in the designated centre Kells Court supported by an adequate staff team

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Update on Training:
• All staff members have now completed their Safeguarding Training.
• 2 staff are booked for Fire Safety Awareness Training on the 20/02/2020. One staff member is attending the refresher training on the 05/03/2020.
• One staff member is due a refresher training in Manual & Patient handling and scheduled for completion on the 02/03/2020.
• The SPC training department is in contact with the HSE to request further dates regarding Dysphagia training to ensure SPC staff can complete training needs. The next dates are proposed to be held latest by end of March 2020. The PPIM and PIC will ensure staff members from Kells Court will attend this training.

A centre specific training profile, individual employee training profiles and a training schedule are distributed monthly to the PIC and PPIM of the centre by the Training Department. The new PPIM and PIC will ensure that employee training is on the agenda of monthly team meetings and also discussed individually through Quality Conversations, which have re-commenced and are scheduled with each staff member. The PPIM has scheduled Quality Conversations with each staff member to be completed by the 06/03/2020 as part of the handover for the new PIC.

SPC has a Quality Conversations policy in place. The policy outlines a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for employees. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.

To build capacity around Quality Conversations and Coaching as a leadership style three Quality Training Session are scheduled for all SPC PIC's and Team Leaders to attend. The first training was completed on the 06/02/2020. Two further training sessions are scheduled for the 17/02/2020 and the 24/02/2020. The PPIM and PIC have attending the first two training sessions and are scheduled also to attend the last training

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
SPC Senior Management Team have decided, until full de-congregation of campus is completed by the end of 2020, the Assistant Director of Service will be supporting Kells Court, Lissadell and Greenfields as PPIM to ensure effective management and governance of the designated centres. The new PPIM commenced in her governance role after the inspection took place on the 25/01/2020.

Registration for a new PIC for Kells Court was submitted via HIQA portal on the 03/02/202. The new PIC will have responsibility for Kells Court 1 and 3, as Kells Court 2 has closed since the inspection took place and two people supported moved to their new community home on the 28/01/2020. Kells Court 3 will be closing after the 16/03/2020, as one person supported is moving to a new home in the community. There will be 3 people supported living in Kells Court 1 after the 05/03/2020, as one person supported will be moving to her new community home.

Handover meetings between the previous PIC and the new PPIM have started on 30/01/2020. Handover between the previous PIC and new PIC is scheduled for the week commencing 02/03/2020.

The Director of Service and PPIM have also met with the staff team in Kells Court on 14/02/2020 and the 17/02/2020 to discuss the HIQA inspections and identified non compliances to reflect on practices and delegate duties to each staff member regarding actions arising from the inspection.

The PIC reports directly to the PPIM, who in turn reports directly to the Director of Service to ensure good governance for Kells Court.

Provider audits:
An annual provider audit was completed in 2019. A 6 monthly provider audit is currently in process and will be completed by the 20/02/2020.
Based on both provider audits the PPIM and PIC are currently developing an action plan and delegated duties for the staff team. The action plans are also part of the handover between the previous PIC and the new PIC to ensure handover.
The PPIM and PIC will follow through on actions through their scheduled Quality Conversations and team meetings with the staff team.

The PPIM has scheduled weekly meetings with the PIC of Kells Court to ensure a weekly update on identified actions and progress on the workplan for the designated centre. This will be ongoing until closure of SPC campus.

Quality Conversations:
The PIC and PPIM have scheduled Quality Conversations with all staff members in Kells Court immediately after the inspection took place. All Quality Conversations will be completed by the 06/03/2020.
The PIC is focusing in the Quality Conversations currently on delegated duties, keyworker duties, actions arising of those and training needs for the staff member.

The PPIM and PIC have monthly to 6 weekly Quality Conversations and also attend the Team Leader and Cluster meetings.
The PPIM has monthly Quality Conversations with the Director of Service.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Outline how you are going to come into compliance with Regulation 13: General welfare and development:

The Director of Service and the PPIM have discussed the identified non-compliance with the staff team at meetings on 14/02/2020 and 17/02/2020. The inspection, HIQA report and institutionalized practices were highlighted and discussed with the team.

A review of visioning for all people supported is scheduled in Kells Court to ensure a reflection on identified roles, goals and meaningful activities. This review will be completed for each person supported by 30/03/2020.

The PPIM and new PIC ensure that the Roles Based Planning toolkit is implemented to document the identified roles and goals and evidence progress of actions being taken for each person supported.

The PPIM and PIC follow up on identified actions through the scheduled Quality Conversations and in team meetings to support the staff team in implementing and progressing with visioning documentation.
Both the PPIM and PIC have completed SRV champions training in SPC. This will ensure to build up competency and knowledge around socially valued roles within the staff team and support the people living in Kells Court to develop personal relationships and links in the wider community.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As SPC is currently in the last phase of de-congregation, ongoing closure of houses is evident on old SPC campus.
Since the inspection took place, two people supported have moved from Kells Court 2 to their new community home. Kells Court 2 is now closed. One person supported living in Kells Court 3 is currently in transition planning for his new community home. The moving date is scheduled for the week of the 16th March 2020. This move will ensure that Kells Court 3 can be closed.

Four people living in Kells Court 1 are awaiting their transition in their community homes. One person is due to move to her community home on the 05/03/2020. The remaining three people supported will be transitioning to their new home in the community later in 2020.

The PIC has highlighted with SPC maintenance department and the staff the removal of items stored outside of Kells Court. This has been addressed and items, e.g. like a garden swing being stored appropriately.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
Due to one person's transition plan being re-viewed just before Christmas 2019 and a new community home been identified for this person, the staff team had not been evidencing the transition and action planning in the person's file.

The person supported is currently awaiting transition to her new community home, which is scheduled for the 05/03/2020. Action Plan meetings are scheduled on a weekly basis, with the PIC, staff members and also people supported attending at times.
Transition plans were updated for the person supported and now available in the person's file. The person supported is visiting her home with her future house mates and finalising her purchase of furniture and personal items.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The PPIM and PIC will ensure a complete revive of the risk register for Kells Court as part of the new action plan for the designated centre. Immediately after the inspection the PIC has delegated the action of reviewing all current risk assessments in Kells Court to the staff nurse and social care worker of the staff team. Risk assessments and the risk register will be discussed at team meetings going forward. The reviews of risk register and risk assessments in line with SPC policy will be completed by 30/03/2020.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Outline how you are going to come into compliance with Regulation 28: Fire precautions: A fire drill was completed on 16/02/2020. The PIC was overseeing the fire drill and ensured that evacuation times and scenarios of the drills are now documented. The procedures and learning of these drills were discussed between the PIC and the staff team. Fire drills, procedures and learning are part of the team meetings agenda going forward in Kells Court.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The PPIM has scheduled a full review of the restrictive practices in Kells Court. Staff members were assigned duties to assess and review the restrictions for people supported, which will then be discussed with the PPIM and new PIC. A full review of restrictive practices in Kells Court will be completed by 30/03/2020.	

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure residents rights are being upheld the management structure for Kells Court was reviewed and a new PPIM and PIC assigned to support the staff team.
The PIC and PPIM addressed institutionalised practices immediately after the inspection took place. Additionally the DOS and PPIM met with the staff team on the 14/02/2020 and the 17/02/2020 to discuss the HIQA report to make staff aware of practices in Kells Court, which do not upheld people supported's rights.

The new full time PIC is assigned to Kells Court to ensure presence in the designated centre. This PIC will support the staff team in their approach with the people supported and implement a person centred atmosphere.

Residents meetings are scheduled for the people supported, the new PIC will attend the meetings to guide the staff team and help people supported voicing their wishes.

The new PIC of Kells Court has completed SRV champions training and also Coaching training provided by SPC to build additional competences in her leadership skills to promote a person centred environment with the staff team in Kells Court.

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(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	30/03/2020
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	30/03/2020
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in	Not Compliant	Orange	29/02/2020

	accordance with their interests, capacities and developmental needs.			
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	10/02/2020
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	17/02/2020
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.	Not Compliant	Orange	05/03/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately	Not Compliant	Orange	06/03/2020

	supervised.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	18/02/2020
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	18/02/2020
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	02/03/2020
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	Not Compliant	Orange	06/03/2020

	to residents' needs, consistent and effectively monitored.			
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.	Not Compliant	Orange	20/02/2020
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential services through:the provision of information on the services and supports available.	Not Compliant	Orange	18/02/2020
Regulation 25(3)(b)	The person in charge shall ensure that residents receive support as they transition between	Not Compliant	Orange	18/02/2020

	residential services or leave residential services through:where appropriate, the provision of training in the life-skills required for the new living arrangement.			
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	30/03/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	16/02/2020
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	Substantially Compliant	Yellow	16/02/2020

	followed in the case of fire.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/03/2020
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	30/03/2020