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:	Tús Nua
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	07 December 2021
Centre ID:	OSV-0005698
Fieldwork ID:	MON-0031524

About the designated centre

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

In this centre a full-time residential service is provided to a maximum of three adults. In its stated objectives the provider strives to enable people to live a good life, with supports and opportunities to become active, valued and inclusive members of their local community.
Residents present with a broad range of needs and the service aims to meet these physical, mobility and sensory requirements. The premises comprises of two houses. Houses are two storey and semi-detached. Both houses are equipped with all facilities that a comfortable modern home would have. Each resident has their own bedroom and two residents share communal, dining and bathroom facilities. The houses are located in a populated suburb of the city and a short commute from all services and amenities.
The centre is operated on a social model of care. The staff team is comprised of social care staff and care assistants. The team work under the guidance and direction of the person in charge. Ordinarily there are four staff on duty each day, three in one house and one in the other house. There are two waking night staff except on occasions when there are only two residents in the house at night, when one waking night staff suffices.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Tuesday 7 December 2021	9:30 am to 5:30 pm	Sarah Mockler	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the three residents that lived in this designated centre. To gather a sense of what it was like to live in this centre the inspector spent time observing the residents as they completed their daily routines, spoke with staff that were familiar with the residents' specific needs and completed documentation review. The overall impression was that residents were well cared for in their home. Some improvements were required to ensure residents' safety was optimised at all times. In addition to this a number of areas of improvements were noted across a number of regulations to ensure that a quality based service could be continually offered and developed.

This inspection took place in the midst of the COVID-19 pandemic. As such adherence to best practice in infection prevention and control measures where adhered too at all times.

The designated centre comprises two separate semi-detached houses that were located beside each other in a residential setting near an urban area in Co. Kilkenny. On arrival at the centre it was noted that new windows and doors had been recently put in place and presented as a welcoming entrance into each of the homes. Two residents lived on one semi-detached home and one resident lived in the second semi-detached home. The person in charge described the relationship between the residents in the two separate homes as 'neighbourly' and interactions were limited to social occasions. This was appropriate due to residents' specific assessed needs.

Residents used different means to communicate, including some verbal skills, behaviours, gestures and facial expressions. Residents choose not to interact with the inspector but tolerated them observing their routines and were noted to frequently smile when spoken too.

On arrival at the first home, a resident was preparing for an upcoming medical appointment. They were sitting and relaxing in their new comfortable chair in their living room. They appeared comfortable and content. The resident was being supported by a familiar staff member and a second staff member had been assigned on this day to help support the resident while attending their appointment. Staff indicated that the resident found it difficult at medical appointments and could become anxious. In order to best support the resident familiar staff were required.

This residents' home was clean, homely and nicely decorated. The resident had access to a small sitting room and kitchen, an individual bedroom and accessible bathroom. There was also an upstairs area with a staff office, bedroom which was being used for storage and a staff bathroom. The resident did not access this area. The sitting room door lead out to a concrete area with a ramp and two steps to either side. A lovely well kept garden area lead off this area. The person in charge discussed how the resident was refusing to go out to the garden. The person in charge identified this as an accessibility issue as the ramp and steps posed some

difficulty to this resident. Overall the interior was well kept, however, due to chipped paint and recently installed windows the area required painting. This had been identified and the resident had recently been involved in choosing paint colours for their home.

The inspector went to meet with the two other residents in the other home. One resident was relaxing in their sitting room and the other resident was walking up and down the kitchen. They were seen to check their personal phone. Both these residents choose not to speak or interact with the inspector. The appeared comfortable and freely accessed all parts of their home. These residents were being supported by two staff member. One of these staff members had been involved on one residents care for over ten years. Staff were very familiar with residents specific needs, and communication skills and spoke in a caring and respectful manner about them at all times. One resident was seen to freely access the garden. A large swing was in the garden and the resident was seen to use this piece of equipment. The staff discussed how this piece of equipment helped with sensory regulation. The resident was seen to laugh and smile while on the swing.

Staff were seen to help prepare residents lunch and sit with residents and enjoy a drink together. Staff checked in on residents on a regular basis to ensure they were ok and involved in daily routines in line with their assessed needs. Later in the day a resident was accessing their tools. This is an activity that this resident greatly enjoyed. There were storage areas inside the home and in the shed for these items. The resident with prompting from staff showed the inspector some of these items.

The interior of the second home required some significant improvements. Although this had been identified by the provider the timeliness of accessing these works required improvement. This will be discussed further in the report. The whole house required painting, parts of floors had exposed concrete, there was a damp patch on the roof in the hall, kitchen cupboards required repair, bathroom fittings required replacing. These works were needed to ensure the home was well kept, homely and a good standard of infection prevention measures could be adhered too.

Documentation review and pictures displayed around the home and captured on residents individual personal tablets, indicated that residents were encouraged to partake in activities that were meaningful to them. Family connections were maintained, encouraged and facilitated at all times. The person in charge identified the importance of keeping family members an active part of each residents life and communication and family visits occurred on a regular basis for each resident. The inspector had the opportunity to review some pictures of residents engaging in activities over the previous few months, residents were visiting places of interest, beaches, visits to cafes and restaurant to name a few. In these pictures residents were smiling towards the camera and were seen to be in the company of peers and or staff. They seemed to be enjoying their days out. A sample of daily notes were reviewed which indicated that residents met family, completed daily chores and activities, went shopping for personal items and items for their home, swimming, walks in places of interest and met with friends for takeaway or meal.

The next two sections of the report present the findings of this inspection in relation

to the governance and management arrangements in place in this centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

In the previous two inspections which took place in May 2018 and July 2020 it was identified that improvements were needed to ensure management systems within the centre were effective. Similar findings were found on this, December 2021 inspection. Such improvements were needed to ensure the service was consistently delivered, effectively monitored and safe. and . A number of areas of regulation required addressing including staff, access to refresher training and supervision of staff.

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

The registered provider had developed an audit schedule to ensure that a range of areas of service provision were monitored. On review of this system it was found not be be consistently implemented. An annual review of the quality and safety of care had not occurred. Six monthly provider unannounced visits had occurred within the relevant time frames. Other audits such as finance, medication, and health and safety audits were not occurring in line with the organisations stated time lines. Many audits were dated 2020 and there were an absence of audits occurring in 2021. These systems were not identifying areas of quality improvement.

Staffing levels ensured that the level of care provided was safe and that residents' needs in the home were being met. On the day of inspection staff interactions were noted to be professional, caring and in line with residents assessed needs. Some staff had been working with some of the residents for a long period of time and were very knowledgeable of their specific needs. The person in charge strived to achieve continuity of staffing and recognised the need to this for the residents in the home. On the day of inspection there were three whole time equivalent vacancies. This meant that the required number of staff were not available to support residents in the community. Some residents were assessed to have two support staff with them at all times in the community. At times, due to staff shortages from absences and staff vacancies, this staffing level was not available. Community access for these residents was limited on these days.

The training records were reviewed by the inspector. These records indicated that staff were required to have specific mandatory training completed. Some of this

included, safe administration of medication , fire safety, safeguarding vulnerable adults and managing behaviour that is challenging. The provider had also listed training that was specific for staff to have completed to work in this designated centre, such as epilepsy awareness and administration of rescue medication. The records viewed indicated that a number of staff required training and or refresher training in a number of these areas. For the most part this had been identified and many staff were booked on trainings in the coming weeks. In addition to this supervision, known as quality conversations was not occurring in line with the organisations policy.

Regulation 15: Staffing

Although staffing levels were sufficient to meet the care needs of residents in the home and ensure residents were kept safe, a number of staff vacancies resulted in insufficient staff being rostered to enable community participation for residents on some occasions.

Two residents in this home were assessed to need two staff with them at all times when out in the community. This was to ensure each residents safety and relevant risk assessments were in place. This meant that in total three staff were required on the roster each day. A review of this documentation indicated that this ratio of staff was not always available.

Judgment: Substantially compliant

Regulation 16: Training and staff development

For the most part, staff had completed training and refresher training in line with the organisation's policies and procedures, and the residents' assessed needs.

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

Judgment: Not compliant

Regulation 23: Governance and management

Although there were management systems in place such as audits, team meetings and staff supervision, they were not effective in ensuring comprehensive oversight at all times. Significant improvements were required in relation to fire safety to ensure residents were safe at all times. This is addressed in Regulation 28.

There was no annual review report of the quality of care and support provided in the centre. Audits were not occurring within stated time lines. There was no overarching system in place to ensure actions were being addressed once identified from audits. Audits at times were not adequately identifying issues that were present as found by the inspector. Some actions that had been identified by the provider in May 2020, such a premises improvements still remained outstanding on the day of inspection.

Team meetings were not occurring on a regular basis.

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

Judgment: Not compliant

Regulation 31: Notification of incidents

Although relevant incidents were notified to the office of the chief inspector, a small number of incidents had not been notified within the required time frames. This occurred during a period of time when the person in charge was mainly based in another designated centre. Systems required review to ensure incidents were reported in a timely manner.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The inspector found that there were systems in place to ensure oversight of complaints in the centre. There were relevant policies and procedures in place. There was a central log to record complaints. On the day of inspection there were no open complaints.

Judgment: Compliant

Quality and safety

The provider and person in charge were striving to ensure residents were in receipt of a good quality and safe services. From what the inspector observed residents lived in a warm and comfortable homes, where they appeared happy and content. Some works had been completed to ensure the home was modernised. However, some areas of the home required significant works to ensure they were fit for purpose, in good condition and were able to be cleaned to an appropriate standard. Improvements were also required in the personal planning process, protection against infection, fire containment and evacuation procedures and risk management.

As previously mentioned, the premises had undergone some recent renovation works. New windows and doors had been installed. The centre was overall clean, homely, and well maintained. Residents' bedrooms were personalised to suit their tastes. There were cleaning schedules in place to ensure that each area of the centre was regularly cleaned, including regular touch point cleaning. The provider had developed or updated existing policies, procedures and guidelines to guide staff in relation to infection prevention and control during the pandemic. There were adequate supplies of personal protective equipment (PPE). Staff had completed a number of infection prevention and control related trainings since the start of the pandemic.

However, some areas in one of the homes required some significant improvements. This had been identified in audits in May 2020 and some work was in the process of being scheduled to be completed, such as painting. However, works was also required in kitchen, halls and bathrooms. The condition of some of these areas did not assure the inspector that effective cleaning could be completed at all times.

The inspector reviewed a sample of residents' personal files. Each residents' health, personal and social care needs were assessed through annual health assessment, visioning assessment and daily living checklist. On review of one resident's file, no daily living assessment had been completed to date. The residents had clearly identified person-centred identified roles and goals. This was completed through an annual review namely called a visioning meeting. On review of a resident identified goals very limited evidence was available on the progression of these targets.

There were some systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. On the day of inspection, doors which were installed to contain fire were not adequately closing, including a door to a utility room with a washing machine and dryer. The person in charge immediately organised for these to be fixed. In addition to this on review of fire drills, it was noted that one resident had refused to take part in a fire drill on most occasions. This was well documented in the drills. However, although this had been identified limited oversight of the drills had meant that limited actions had been taken to address this. The person personal evacuation plan had not been updated to

reflect this information. These are two examples in which fire safety management had the potential to present risks to the systems in place to protect residents in an emergency situation. Oversight of fire safety required significant review and continuous oversight to ensure it was best meeting the needs of residents.

Regulation 17: Premises

The designated centre comprises two semi-detached homes located close to an urban area in Co. Kilkenny. All residents had their own bedrooms which were decorated to reflect their individual tastes with personal items on display. Recent renovation works had modernised the standard of the home.

In one house, and the majority of rooms presented as inviting, well kept areas. Some painting work was required but this had been identified by the registered provider and there was a plan for this to commence in the new year. The sitting room at the back of the house had double doors that lead out to a garden area was large and overall well kept. To gain access to the garden area there were two steps down or alternatively a ramp which steep decline. The resident refused to utilise the ramp or the steps to gain access to the garden. The accessibility of this part of the resident home required review.

In the second home more significant premises works were noted. In the downstairs hall there had been a leak and a wall and ceiling were damaged. Kitchen presses were in poor condition. Upstairs, some of the floor missing with a large patch of cement exposed. Bathroom fittings were broken and there were marks on the bath. Paint work was chipped and or marked on walls, skirting and doors. In May 2020 a number of these improvement works were identified ,however, remained incomplete on the inspection day in December 2021.

Judgment: Not compliant

Regulation 26: Risk management procedures

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

Judgment: Substantially compliant

Regulation 27: Protection against infection

Due to the condition of some parts of one of the homes the inspector was not assured that all parts of the home could be cleaned to a high standard to ensure effective infection control procedures were in place. For example, the missing part of the floor had exposed concrete. In addition to this, appropriate waste management systems were required in the form of pedal bins in some areas of the home.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Although there were some systems in place, such as fire fighting equipment, regular fire drills and emergency lighting. Other elements of fire safety were not always effective, therefore residents were not adequately protected from the risk of fire at all times.

Three doors in one of the home, that were equipped to contain fire were not adequately closing on the day of inspection. There were no systems in place to check if these doors were adequately functioning. The person in charge immediately addressed the issue of the doors not closing and contacted the relevant people to come address this.

New patio doors had been installed in both homes. These were identified as fire escape routes. Some of these doors were locked using a key locking system. There were limited systems in place to ensure the key was readily available at all times in the event of an emergency

On review of fire drills it was found that one resident had refused to partake in a fire drills. This was well documented in a number of fire drills reviewed for 2021. However, the only identified learning piece documented was to discuss this at team meetings. There was limited evidence of this on the day of inspection. No risk assessments had been developed and the residents personal evacuation plan had no details in relation to this. The provider had made attempts to contact the local fire officer in relation to advice in this matter, however this had only occurred in October 2021.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

A sample of residents personal plans were reviewed. To assess residents health, social and daily living needs different assessments and checklists were utilised. On review of one resident's file there was no daily living checklist so it was unclear how some of of the residents personal goals were being identified and reviewed on a regular basis.

Although there were systems in place to monitor the effectiveness of social goals as identified in the annual visioning meeting, there were some gaps in the documentation. For one resident there was no progress recorded for three out of four goals since quarter one of 2021. Therefore it was unclear if residents goals were being progressed in line with residents' wishes and needs.

Judgment: Substantially compliant

Regulation 6: Health care

The residents were being being supported to access good health care. They had their health care needs assessed and care plans were developed and reviewed as required. Some resident were presenting with complex needs associated with their diagnosed health condition. Appropriate care, referrals and follow up was been utilised to ensure this person's needs were being met to the best of the providers ability.

Residents had access to health and social care professionals in line with their assessed needs

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had systems to keep the residents in the centre safe.The residents were observed to appear relaxed and content in their home. Staff were knowledgeable in relation to relevant safeguarding procedures and they identified who they would report any safeguarding concerns too.

Judgment: Compliant

Regulation 9: Residents' rights

Resident rights were upheld and respected. Staff treated all residents with dignity and respect. Residents were consulted with on different aspects of how the

designated centre was run. Residents attended regular meetings with staff were different aspects of their care and support were discussed. For example, in a sample of notes reviewed it was documented on how a resident was choosing new paint colour for their home.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

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

Compliance Plan for Tús Nua OSV-0005698

Inspection ID: MON-0031524

Date of inspection: 07/12/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
SPC recruitment is ongoing and one employee has started in Tus Nua on the 13/12/2021. The vacancies of 2 WTE are currently filled with relief and regular agency staff to ensure all people living in Tus Nua can avail of quality and safe service.

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

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

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

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The PIC has put a plan in place to ensure all outstanding Quality Conversations are completed by the 31/01/2022. The PIC has also developed a schedule for completion of Quality Conversations for 2022 and is also using the opportunity for themed, short notice Quality Conversations as per SPC policy.

Quality Conversations are incorporated in the draft Compliance Manual which was presented at a Quality & Compliance Working Group session with middle and senior management on the 13/01/2022.

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

All mandatory refresher training has been completed by staff members. Two staff members are due their refresher training for Food Safety in January 2022 and will book the upcoming courses on 20/01/2022 and 09/02/2022. One staff member is due refresher training in Buccal medication and will complete same as soon as returning from sick leave.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Completion of the Annual review is scheduled by the Community Service Manager for 28/01/2022. The PIC will ensure the findings of the audit and action plan will be discussed at the team meeting 08/02/2022. Actions are delegated to staff members for completion and progression of same monitored by the SCW on a weekly basis and by the PIC through Quality Conversations.

Team meetings are now held on a monthly basis in Tus Nua. The next team meeting is scheduled for completion on the 25/01/2022. The PIC and PPIM will address at this meeting the importance of completion of audits and follow up on actions by the staff team. This is also being discussed in Quality Conversations with the staff team and On the Job mentoring provided to members of staff to build their understanding of initiative and delegated duties. Night staff will oversee the completion of audits as per SPC schedule and report to PIC of outstanding actions.

The PIC has put a plan in place to ensure all outstanding Quality Conversations are

completed by the 31/01/2022. The PIC has also developed a schedule for completion of Quality Conversations for 2022 and is also using the opportunity for themed, short notice Quality Conversations as per SPC policy. The staff members use their developed action plans from Quality Conversations to follow up on delegated duties and tasks.

The PIC will address responsibilities and delegated duties with the Social Care Worker in the next Quality Conversation on the 17/01/22 to ensure support regarding governance & management in the designated centre and review night duties in Tus Nua.

The PIC will also discuss the SPC workplan in the absence of PIC with the staff team to build capacity in their understanding of delegated duties.

Development of a Compliance Manual: Community Service Manager and Quality Manager are currently developing a manual based on each regulation, outlining SPC policies, processes, pathway, systems, audits in place relevant to each regulation. This manual will help employees to gain a better oversight and understanding on the systems to be followed within each regulation. A draft version of this manual will be presented at Quality and Compliance workshop on the 13/01/2022. PPIMs and PICs can avail of this manual to discuss delegation of duties with their staff teams.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC has submitted two monitoring notifications outside the timeframes due to work remit at the time of the incidents. The PIC has addressed this issue with the PPIM in their Quality Conversation on the 19/11/2021 to ensure the PPIM will support the PIC in overseeing completion of notifications within the regulatory timeframes.
The PIC discussed with the staff team on 29/12/2021 the responsibility of highlighting the necessity for monitoring notifications to be completed as part of incidents within the designated centre. This is also added to the team meeting agenda for the 25/01/2022 and with the SCW to oversee Regulation 31.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The following repair and maintenance work is scheduled in Tus Nua as follows:

- Internal painting work is commencing on the 19/01/2022.

- Access to garden for one person supported in Tus Nua has been reviewed on the 06/01/2022, ramp will be extended & be completed Mid-February 2022.

- Replacement kitchen unit doors reviewed and will be replaced (subject to availability) latest mid-March 2022.

- New Bath to be installed week commencing 17th March 2022.

- Worktop purchased and will be installed week commencing 17th March 2022.

- New flooring downstairs & stairs carpet to be fitted 28t January 2022.

- All blinds to be re-hung, all statutory notices/pictures etc. to be rehung on completion of the above.

Respond the Approved Housing Body have repaired the part of the floor they damaged during renovations and concrete is no longer exposed.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk register is under review with the PIC and staff team as part of the monthly reviews for people supported. All person's risk assessments will be reviewed and completed by latest 30/01/2022. Risk assessments for one person supported have already been reviewed and updated. Annual review for another person supported is scheduled for the 19/01/2022, all risk assessments will be reviewed and updated as part of preparation for the annual review.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The missing pedal bin has been put in place on the day of the inspection.

All necessary repair works have been scheduled for completion as outlined under Regulation 17.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The three fire doors were repaired on the day of the inspection. The PIC has added the completion of fire checks to the team meeting agenda to ensure fire checks, closure of fire doors, etc. are completed to a high standard and any issues arising are reported to the PIC and maintenance team.

The PIC will also address quality of completion of fire duty with the relevant staff member in their Quality Conversations.

The PIC and keyworker have reviewed the person's PEEP to reflect the supports needed for this person to engage in an evacuation. The fire officer is scheduled to visit Tus Nua in February 2022 to give guidance to the PIC and staff team. The PIC is awaiting a date for this visit.

A Fire Door Safety Audit was conducted by B. Moore Architects on the 13/1/2022 and a Fire Door Upgrade Schedule is now in place.

The new patio doors key locking system has been replaced with a thumb turn lock on the inside on the 14/01/2022.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The daily living checklist has been completed for all people supported in Tus Nua.

The PIC has re-organised the staff team to ensure better oversight and also capacity building regarding person-centred planning. Each staff member has now a key working responsibility as part of the planning process. Through the Quality Conversations the PIC is providing On the Job mentoring regarding SPC Personal Planning Framework, the Social Care worker will provide day-to-day support to the team and oversee completion of monthly reviews for all people living in Tus Nua. The staff team can avail of support from the Service Enhancement Team to build capacity regarding person centred planning.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2021
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	09/02/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/01/2022

Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	17/03/2022
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	17/03/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	08/02/2022
Regulation 23(1)(d)	The registered provider shall	Not Compliant	Orange	08/02/2022

	ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	19/01/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	07/12/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting,	Not Compliant	Orange	14/01/2022

	containing and extinguishing fires.			
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.	Not Compliant	Orange	14/01/2022
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Substantially Compliant	Yellow	19/11/2021
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.	Substantially Compliant	Yellow	14/01/2022
Regulation 05(6)(c)	The person in charge shall	Substantially Compliant	Yellow	14/01/2022

	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.			