Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Kilfane House
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	05 November 2020
Centre ID:	OSV-0007863
Fieldwork ID:	MON-0030512

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 5 November 2020	09:40hrs to 15:40hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

This inspection took place in the backdrop of the COVID-19 pandemic. Communication between the inspector, the residents, staff and management took place in adherence with public health guidance. Overall, the inspector found a calm and relaxed environment provided for the residents of this centre.

There were four residents present on the day of the inspection. All of these residents had transferred together into this centre at the beginning of September from another designated centre and at the time of this inspection had been living in the centre for just over a month. This home had been purpose built for the residents that were living there. The residents were seen to spend a significant portion of their day in the large open plan kitchen/sitting room of the house. This was spacious with ample natural light through large windows and doors that led out to a pleasant enclosed courtyard area.

The inspector had an opportunity to interact with and observe all of the residents in their home on the day of the inspection. On the day of the inspection, the inspector observed a chiropodist visit the residents in the centre. Staff were overheard to provide support and encouragement to residents while they received this treatment. The inspector observed residents relaxing watching television and looking at preferred magazines, and enjoying hand massages. One staff member was observed painting a residents nails, with the resident appearing to enjoy this activity and the associated one-to-one interaction with staff. Staff were seen and heard assisting residents to get ready to go out and support a resident to assist with putting away laundry in the centre. Residents were also observed enjoying meals and snacks throughout the day.

Capacity and capability

This centre was a newly built designated centre that was registered during the COVID-19 pandemic and this was the first time it had been inspected. This was a risk based inspection completed to assess the quality of care and support that the residents now living in the centre were receiving. The findings of this inspection were generally positive. However, on the day of the inspection, the inspector found that the centre was not meeting the assessed needs of one resident. Some improvements in oversight were required in the some areas such as healthcare, infection control and residents' rights.

There was a clear management structure in place in the centre. The person in charge was present on the day of the inspection and the community services manager, who participated in the management of this centre, also met

briefly with the inspector. The person in charge commenced in this role shortly before the transition of these residents to this centre and had worked with the residents in their previous designated centre. This individual occupied a full time role and had remit over two other centres at the time of this inspection. The inspector found that they maintained a strong presence in this centre. The area manager had commenced in their role six weeks prior to the inspection also. Both of these individuals had the required qualifications and experience for their roles. Staff told the inspector that the management team were supportive and that they responded in a timely manner to any concerns that staff had. The person in charge told the inspector about how they maintained oversight and plans they had for the future running of the centre, and the inspector found that this person was committed in their role and was assured that they had the appropriate skills and knowledge for the role. Some deficits in infection control practices in the centre, and some issues in relation to risk and residents' rights had not yet been identified by the newly appointed management team prior to this inspection. These will be discussed in further detail in the quality and safety section of this report.

This premises had been purpose built by the local county council for these residents and was intended to be a long term home for them. The provider had developed a briefing document to be provided to the county council and the developer that outlined the specific requirements of each resident. The inspector viewed a comprehensive occupational therapy report that had been completed in respect of one resident in 2019. This resident required the use of specific aids and appliances such as a raised toilet seat and this document stated that this resident would require an en-suite bathroom in any future accommodation, with a further email from this health professional on file in June 2019 restating this fact. However, there was no en-suite bathrooms in this premises and the briefing document, transition plan, or any other documentation around the residents moving into this centre, did not include any reference to this important assessed need of a resident. The inspector acknowledges that both the occupational therapy report and the briefing document were completed prior to the current management of this centre commencing their roles. However, transition planning carried out prior to the admission of residents had not identified this important issue. In the weeks following this inspection, the person in charge informed the inspector that the occupational therapist had since visited the premises and found it to be suitable to meet the needs of all of the residents living there.

A staff rota was viewed. This showed that there was an adequate number of staff with the appropriate skill mix to meet the needs of residents in the centre. A dedicated team was in place to ensure continuity of care was provided to the residents, and the use of agency staff was low. Nursing input was available to residents. The staff team from the residents' previous designated centre had transferred with the residents to this new centre and some staff had worked with these residents for a number of years. The inspector spoke to a newly recruited staff member who was on duty on the day of the inspection. They told the inspector about the positive induction process in the centre. Where agency staff were employed, there were induction procedures in place and the provider had put arrangements in place to ensure that these staff were appropriately trained. The person in charge told the inspector that, where possible, unfamiliar staff would not

lone work in the centre. The provider had in place a contingency plan that included details about how staffing levels would be maintained in the event that staffing levels in the organisation were depleted or that staffing needs increased due to an outbreak of the COVID-19 virus.

Registration Regulation 5: Application for registration or renewal of registration

An application to register the designated centre had been received in the correct format and included the required information.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that there was a sufficient number of staff on duty in the centre to meet the residents assessed needs. The number, qualifications and skill mix of staff was appropriate and continuity of care was evident. There was a planned and actual staff rota in place.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had established a directory of residents within the designated centre and this contained the required information as set out in Schedule 3 of the Regulations.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre was appropriately resourced to ensure the effective delivery of care and support. There was a clearly defined management structure in place and appropriate support was provided to staff by management. Overall, the management of this centre had systems and plans in place to maintain oversight and maintained a strong presence in the centre. However, systems in place had not ensured that the service provided was at all times safe and appropriate to resident's needs. One resident required the use of an en-suite and this had not been identified

in a planning brief document submitted to the county council or in the transition plans or documentation around the transfer of the residents into this centre. Also, some poor practices in the centre in relation to infection control and fire safety had not been identified prior to this inspection.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place in respect of this centre and this had been submitted to the office of the chief inspector as part of an application to register this designated centre. This important document was present in the centre on the day of the inspection and contained all of the required information as per the regulations.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Residents and their families had been offered an opportunity to visit the centre prior to being admitted. Contracts of care were viewed and these set out the terms and conditions of residency and the fees and charges payable by residents. A sample of contracts of care in place viewed by the inspector had not been signed by the residents or their representatives.

Judgment: Substantially compliant

Quality and safety

The quality and safety of the service provided in this designated centre was looked at. It was found that this new home presented as a positive move for the residents that were living there and would provide for greater opportunities for community access and integration. Some issues were identified in the areas of fire safety, personal planning and residents rights. This inspection also found that while the provider had strong documentation in place in relation to infection control, this was not always reflected in everyday practices in the centre.

The centre was newly built and the premises was found to be well maintained and presented throughout. The exterior of the centre included a courtyard that was pleasant and accessible to the residents and the person in charge told the inspector

about plans to use this space going forward. Residents' bedrooms were personalised and nicely decorated and the centre was bright and spacious, with ample storage and appropriate cooking and laundry facilities for the residents living there. The centre was fully accessible throughout and some bedrooms had been equipped with overhead hoists. This provided for the possible future needs of residents and it was anticipated that this would ensure that residents would be able to remain in their home long term, should their mobility needs increase. Some issues relating to appropriate bathroom facilities for a specific resident are dealt with in the capacity and capability section of this report.

There was a dedicated area in the centre that was suitable to facilitate residents to receive visitors in private if they wished. Visiting during the COVID-19 pandemic was restricted in line with government restrictions and where visits did take place, control measures had been put in place in line with public health guidance to minimise the risks associated with the COVID-19 virus for residents, their families and staff members in the centre

The inspector viewed a sample of individualised assessments and personal plans in place in the centre. Plans provided good information for staff about residents support needs and comprehensive transition plans in accessible format were in place for residents. Goals relating to transitioning to this new centre had been completed and the person in charge told the inspector about plans to complete visioning and personal planning meetings with residents and family members in the coming month to discuss and develop new goals for residents. As mentioned previously in this report, one resident had been assessed in 2019 as requiring an en-suite bathroom in any future placement. The inspector found that although an assessment had been completed in respect of this resident prior to their admission, the arrangements were not in place to meet those needs as assessed at the time of this inspection. Also, despite numerous aids and appliances being prescribed to the residents living in this centre as detailed in their individualised assessments and plans, there had been no specific occupational therapy input in respect of the suitability of the bathroom facilities or the transfer of that equipment to this centre prior to the residents moving in. This was planned for the week following the inspection.

Fire safety systems were in place in the centre, including a fire alarm system, a smoke detection system, emergency lighting and fire doors. There were records of daily checks completed by staff and at the start of each shift fire duties were assigned to the staff members on duty. Appropriate evacuation plans were in place and a fire drill had been completed since the residents had moved into the centre. The person in charge had also arranged to have firemen from the local station visit the house so that they were aware of the layout and evacuation plans in place.

Fire doors were held open by a specialised safety device that enabled the door to remain fully ajar and would close if the door was pulled or if the fire alarm system was activated. These did not allow for doors to remain slightly ajar. The inspector noted that a thumb turn lock had been engaged on an open bedroom door, preventing the door from closing fully. This posed a significant fire safety risk in that it would prevent the fire doors from closing in the event that there was an outbreak of fire in the centre. This was rectified at the time of the inspection and the person

in charge gave assurances to the inspector that this practice would cease immediately. However, the inspector was told by staff working in the centre that this practice was in use to keep the door slightly open at night so that the resident could exit the room independently to use the bathroom at night when their bedroom door was closed. This was because residents were unable to open these doors independently if they were fully closed. The inspector was told on the day of the inspection that two residents could mobilise independently around the centre. Neither of these residents, therefore, could leave freely their bedrooms in the event that the bedroom door was closed. In the weeks following this inspection the person in charge informed the inspector that this issue had since been rectified.

There was a risk register in place. This identified numerous local and individual risks. A number of risk assessments relating to the COVID-19 virus had been completed by the provider. A local risk assessment relating to the COVID-19 virus was also in place. This made reference to a number of standard operating procedures that the provider had put in place. The inspector found that these documents were either not in place, or were not easily located in the centre, and that as a result this risk assessment did not provide accurate and adequate guidance for staff in the event that an outbreak of COVID-19 were to occur in the centre.

The inspector saw that this centre was clean and well maintained. Cleaning records had been reviewed by the person in charge. There were cleaning checklists for each room in the centre, and these were being regularly updated. The inspector saw that visitors to the centre, such as a chiropodist and a contractor had completed appropriate screening forms and visitors were required to have their temperature checked on arrival to the centre. The inspector viewed records of staff temperature screening and noted that some records were incomplete. Staff working eight and 12 hour shifts had completed temperature screening only once during their shift, with no times of these checks recorded. In line with the Health Protection Surveillance Centre guidance, the National Public Health Emergency Team (NPHET) requires that all staff working in residential care facilities have their temperature measured twice per shift, once being at the start of each shift. On the day of the inspection, neither the person in charge or the area manager spoken to were aware of this requirement, or of the providers protocols in relation to temperature checks. During the inspection, the inspector also viewed all three staff taking their lunch break together at the kitchen table in the presence of the person in charge. This meant that all staff were sitting in close proximity to one another while not wearing a surgical mask or face covering. This practice had inherent risks related to the prevention and containment of the COVID-19 virus and the ability of the designated centre to maintain adequate staffing levels should an outbreak occur. This practice was also not in line with either the providers' policies or public health guidance on the use of Personal Protective Equipment (PPE) in disability services.

Some residents had assessed dietary requirements and staff were seen to prepare food in line with the guidance contained in their plans. There was a record of meals offered to residents and this included how residents reacted to the food provided. There were records in place that showed residents had their weight checked on a monthly basis and evidence of regular input from health and social care professionals such as a general practitioner (GP), physiotherapist and dietitian.

A staff nurse held a full time role in the centre, providing nursing oversight as required. On the day of the inspection the person in charge showed the inspector a comprehensive medical data recording sheet that was proposed to be included as part of a new documentation system. These were sufficiently detailed to provide oversight in this area by the person in charge. The inspector had sight of a defibrillator in place in the centre.

Staff spoken to had knowledge of their responsibilities in the area of safeguarding and had completed appropriate training. Residents appeared comfortable in the presence of staff and staff were seen to speak to and support residents in a respectful manner. A finance check completed on the day of the inspection found that monies held in the centre for residents was accurately recorded. Garda Síochána (police) vetting had been carried out for all staff, including agency staff.

Regulation 11: Visits

There was a dedicated area in the centre that was suitable to facilitate residents to receive visitors in private if they wished. Residents and their families had been offered an opportunity to visit the centre prior to being admitted. Visiting during the COVID-19 pandemic was restricted in line with government restrictions and where visits did take place, control measures had been put in place in line with public health guidance to minimise the risks associated with the COVID-19 virus for residents, their families and staff members in the centre.

Judgment: Compliant

Regulation 17: Premises

The designated centre was clean, adequately maintained and and decorated in line with residents individual preferences. There was adequate cooking facilities and outdoor space was available to residents.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared a guide in respect of the designated centre and this was available to the resident. This guide contained all the required information as per the regulations.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Transition plans were in place to support the residents as they transitioned from their previous designated centre to this new centre. These plans were in accessible format and provided information to the residents about the services and supports available to them.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had put in place systems for the assessment, management and ongoing review of risk. A risk register was in place to provide for the ongoing identification, monitoring and review of risk. This required updating to ensure that all risks were identified and managed appropriately and that the information available to staff was accessible and accurate.

Judgment: Not compliant

Regulation 27: Protection against infection

Some practices in the centre were not in line with with public health guidance and guidance published by HIQA. For example, staff temperature screening was not recorded as frequently as was required and staff were observed sitting close together while not wearing appropriate PPE.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety systems were in place in the centre, including a fire alarm system, a smoke detection system, emergency lighting and fire doors. There were records of daily checks completed by staff and at the start of each shift fire duties were assigned to the staff members on duty. Appropriate evacuation plans were in place and a fire drill had been completed since the residents had moved into the centre. A thumb turn lock had been engaged on an open bedroom door, preventing the door

from closing fully. This posed a significant fire safety risk in that it would prevent the fire doors from closing in the event that there was an outbreak of fire in the centre. This was rectified at the time of the inspection and the person in charge gave assurances to the inspector that this practice would cease immediately.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The registered provider had not ensured that arrangements were in place to meet the needs of each resident, as assessed prior to their admission to the centre. Assessments carried out in respect of the individuals living in the centre included recommendations from an occupational therapist that had not been considered prior to the residents transferring to the centre.

Judgment: Not compliant

Regulation 6: Health care

Overall, healthcare was well managed in this centre. Residents had access to a GP as appropriate and were facilitated to make and attend appointments. There was nursing input available if required within the staff team. Staff spoken to had a good knowledge of the residents healthcare needs, including daily requirements to complete prescribed exercises.

Judgment: Compliant

Regulation 8: Protection

Arrangements were in place to ensure that residents were protected from all forms of abuse. Throughout the inspection residents were seen to be comfortable in the presence of staff members. Staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse and Garda vetting was in place for all staff.

Judgment: Compliant

Regulation 9: Residents' rights

Door closure systems in place did not allow residents to enter or exit their rooms independently when these doors were closed.This had not been identified as a restriction on residents' rights at the time of the inspection.
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
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Kilfane House OSV-0007863

Inspection ID: MON-0030512

Date of inspection: 05/11/2020

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There is a clearly defined management structure in place for Kilfane House.
The PIC and PPIM are meeting regularly through Quality Conversations, Cluster and Quality Assurance meetings, on a day to day/needs basis and team meetings to ensure governance and oversight over person supported's needs.

Issues identified on the day in relation to wearing of PPE has been addressed by the PIC on house level and also on provider level. The SPC newsletter to all employees and people supported has addressed the areas of taking breaks and adherence to the SOP in regards of wearing of masks was included.

The PIC addressed completion of COVID-19 related staff and people supported screening forms immediately on the day of the inspection with the staff present and the days after the inspection with the remainder of staff team. H & S department has also sent a reminder to all SPC employees via newsletter to ensure the relevant screening forms are being completed.
The PIC and staff team are fully aware of the correct screening forms to be used and to be found on Q drive.

While we acknowledge that the OT had previously recommended an ensuite bathroom for one lady supported the overall planning for Kilfane House with state-of-the-art bathrooms meet the needs for all four ladies supported.
As an action resulting from the inspection the DOS and PIC met with the OT in Kilfane House to review the current living situation. The OT found the premises and bathrooms to be suitable and meeting the needs of all people supported.

The PIC discussed the HIQA report and all necessary actions with the staff team at the team meeting on the 22/12/2020.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Since the inspection took place all people living in Kilfane House were supported in reading through their Provision of Service documents. This has been documented by their keyworkers on the Easy Read document.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC reviewed the risk register for Kilfane House since the inspection took place to identify any necessary risk assessments or SOPs to be updated or to be completed. The PIC found that all relevant risk assessments and SOPs were in place and reflected in the risk register.

COVID-19 related risk assessments and SOPs developed on provider level are also available on the SPC Q drive (Coronavirus folder) for all employees. To ensure all employees are informed about updates in relation to COVID-19 a weekly newsletter is sent to all employees and people supported.

The SPC standard team meeting agenda has also been updated to include any updates in relation to COVID-19 related risk assessments or SOPs.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The PIC addressed completion of COVID-19 related staff and people supported screening

forms immediately on the day of the inspection with the staff present and the days after the inspection with the remainder of staff team. H & S department has also sent a reminder to all SPC employees via newsletter to ensure the relevant screening forms are being completed. The PIC and staff team are fully aware of the correct screening forms to be used and to be found on Q drive.

H & S department are providing regular updates and reminders in the SPC newsletter in relation to infection prevention & control measures.

The PIC has also completed the HIQA Assurance Framework for infection prevention and control for Kilfane House.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The hold open devices were changed in Kilfane house to ensure that people supported can open doors themselves and move independently within their home. 2 priority doors were completed the day after the inspection took place, all other doors were completed within a week after the inspection.

The PIC and PPIM discussed staff practices of using thumb turn locks on people supported's bedroom doors to ensure this practice is not being used going forward. The new hold open devices enable the ladies supported to open their bedroom doors independently.

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:
To ensure a holistic approach and supports for the ladies living in Kilfane House the new SPC Personal Plan Framework has now been fully implemented. Annual reviews for all people supported were completed since the inspection took place. Progression of roles and goals are now documented within weekly progress sheets and reviewed on a monthly basis.
The layout of new Personal Plan Framework ensures that all person's needs are discussed and necessary actions documented and followed through, such as OT devices.

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: All swing free hold open devices have been adjusted since the inspection took place to ensure all people supported can access all rooms independently in their home.	

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/11/2020
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	30/11/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Not Compliant	Orange	30/11/2020

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	15/12/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	20/11/2020
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	15/12/2020
Regulation 09(2)(b)	The registered provider shall	Not Compliant	Orange	20/11/2020

	ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			