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:	Camphill Community Duffcarrig
Name of provider:	Camphill Communities of Ireland
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	02 March 2021
Centre ID:	OSV-0003610
Fieldwork ID:	MON-0031662

About the designated centre

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

Camphill Community Duffcarrig consists of seven residential units located in a rural community setting, that can offer a home for a maximum of 25 residents. The centre provides for residents of both genders over the age of 18 with intellectual disabilities, Autism and those with physical and sensory disabilities including epilepsy. Each resident has their own bedroom and other facilities throughout the seven units that make up this designated centre include kitchen/dining areas, living rooms, cloak rooms, utility rooms and bathroom facilities. In line with the provider's model of care, residents are supported by a mix of paid staff members and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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 2 March 2021	09:30hrs to 15:30hrs	Tanya Brady	Lead
Tuesday 2 March 2021	09:30hrs to 15:30hrs	Conor Brady	Support
Tuesday 2 March 2021	09:30hrs to 15:30hrs	Louise Griffin	Support
Tuesday 2 March 2021	09:30hrs to 15:30hrs	Sinead Whitely	Support

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic, inspectors adhered to all public health guidance with respect to infection prevention and control. Four units of this centre were included in the inspection. Each inspector inspected one house (to decrease footfall across locations). One house contained two units which were interconnected. These houses were selected as they had not been visited on the previous inspection. Inspectors met with residents, staff and management, observed practice and reviewed documentation. The review of documentation took place in an office space (clean zone) to ensure compliance with public health guidance and HIQA's enhanced inspection methodology. Inspectors met and spoke with some residents when they called to the door of the office space over the course of the day. Also inspectors had the opportunity to observe and meet some residents in daily activities external to the office over the course of this inspection, while ensuring that infection prevention and control measures were implemented. Inspectors met with 16 of the residents over the course of the day.

This designated centre consists of seven residential units located in a rural setting registered to provide care and support to a maximum of 25 residents. There were 23 residents living in the centre on the day of the inspection. The site also contains a working farm, multiple buildings used for activities and day services, accommodation for volunteers and other residential support accommodation that do not come within the registered residential centre. The site was very large (60 acres) with extensive surrounding fields and farmlands. A large chicken pen with poultry and peafowl was located on site also.

Inspectors visited residents' living areas and found very neglectful conditions in one of these areas, conditions that posed a high risk to health and wellbeing. This living environment was found to be extremely unkempt, visibly dirty, with food items, animal waste and medications found on the floor and dried onto the skirting boards. A strong and offensive odour of cat waste (ammonia/urine and faeces) made it difficult for inspectors to stand in the bedroom area.

Inspectors required the provider to take immediate and urgent action regarding this living accommodation. Inspectors did not leave the centre until a deep clean had commenced. At that point eight large black bags of refuse had been removed from the area. Some of the provider’s managers stated that they had visited this living area and had taken no action, but others said that they were not aware of these poor living conditions when questioned about same.

In relation to the rest of the centre, inspectors found that residents were living in premises that were poorly maintained internally and externally. Pathways to some of the houses were muddy and rough under foot in places and a staff member explained that this was an issue in particular for residents with reduced mobility. The surrounds of houses in general were uneven pathways or overgrown marshy grasslands. The premises overall presented as requiring substantive maintenance,

cleaning and repair internally and externally. In one house an inspector noted that work was in progress to re-plaster a ceiling following a leak, caused by poor roofing conditions externally and in another an inspector noted that the gutters and roof were filled with moss. A resident who likes to walk around the grounds directed the inspectors to the correct paths to use when entering and exiting the site. Another resident told inspectors that they were dissatisfied regarding maintenance issues in the laundry, showing inspectors where tiles were falling off the walls in some areas and expressed that they would like to have these fixed.

Staff on duty presented as familiar with residents, their likes and dislikes and their daily routines. Residents who had mobility difficulties were seen to be supported by staff in taking walks and residents who presented with communication difficulties were facilitated by staff to communicate more effectively. One staff member was observed preparing individualised breakfasts for two residents and another resident was supported to share information that was important to them with an inspector.

Inspectors found that while some residents had interesting things to do during the day and seemed happy living in the centre, there was insufficient staffing to provide adequate support to residents and this is discussed under the staffing regulation further on in the report.

In the next two sections of the report the specific regulations viewed by inspectors are outlined and the impact on residents is also highlighted.

Capacity and capability

Following a series of very poor inspection findings in centres operated by Camphill Communities of Ireland in 2020, the registered provider was required to submit a comprehensive national improvement plan by the Chief Inspector of Social Services. Due to the levels of concern found on previous inspections, substantive provider led improvements were required across all Camphill Communities of Ireland designated centres. This national improvement plan was submitted by Camphill Communities of Ireland in October 2020. Due to the seriousness of the regulatory concerns regarding both the capacity and capability of the registered provider and the quality and safety of care and support delivered to residents, the implementation of this national plan is being monitored by the Chief Inspector on a monthly basis. This unannounced inspection formed part of this national monitoring programme of Camphill Communities of Ireland.

This inspection found that the provider continued to be not compliant in areas identified on the previous inspection. There were a number of significant findings on this inspection regarding the safeguarding of residents and the infection control practices and hygiene of this centre which resulted in the provider being required to implement urgent actions on the day of inspection. These findings were inconsistent

with assurances given to the Chief Inspector prior to the inspection by this provider. This centre had not moved towards regulatory compliance in the areas inspected despite the provider's national improvement plan being in place.

Although there were management systems and structures in place, they were not proving effective as they did not ensure full oversight of the service. There was a new local management team and while lines of authority and accountability were in place, inspectors found staff knowledge of these inconsistent and the application of managerial oversight to be very poor. The provider had completed one six monthly unannounced visit since the last inspection. An annual review of the previous year 2020 had also been completed by the person in charge. A number of audits had been completed and management meetings had been occurring in line with the provider's national action plan. However, a review of minutes from these meetings and plans showed that not all actions identified had been implemented. Given the serious findings regarding the living conditions in one area, it was of concern to inspectors that this had not been identified as part of these health and safety audits or the other audits of care and support that management had completed.

The registered provider was aware that there were insufficient numbers of staff to meet residents' assessed needs. Additionally, the skill-mix of staff did not meet the care and support needs of residents as assessed. In reviewing staffing arrangements, observation of care practices, reviewing rosters and speaking with management, staff and residents, the inspectors found that there was not enough staff on duty in the centre. Furthermore the consistency of staffing was poor with daily use of agency staff and volunteers a feature on rosters. Inspectors saw where behavioural support plans indicated inconsistent staffing as a trigger for behaviours of concern and a review of accidents and incidents confirmed same. The inspectors were informed directly by the person in charge at the outset of inspection of the staffing deficits, deficits in qualified personnel, continued over-reliance on unpaid volunteers and of planned industrial action and work stoppages in the coming weeks due to staff discontent with their working conditions. Inspectors reviewed staff personnel files and found that they did not contain all of the information, as required in Schedule 2 of the regulations.

The provider had failed to ensure appropriate staff training and refresher training was provided and staff supervision was not being implemented in line with the organisation's policy. This was evident in the absence of supervision of staff practice, centre oversight and in supervision and training documentation.

On reviewing residents' contracts of care inspectors acknowledge that the new contract was in place for all those reviewed. However on two contracts the incorrect amount was recorded for the charges residents paid for services and amenities.

Registration Regulation 5: Application for registration or renewal of registration

An appropriate application for the renewal of registration of this centre had not been received as required. This centre's current registration expires on 21 July 2021 and the application to renew registration remains overdue.

Judgment: Not compliant

Regulation 15: Staffing

There were not appropriate levels of staffing, skill mix or staff consistency found on this inspection. Staffing was not being provided in accordance with the assessed needs of residents. Agency staff and volunteers were in use to make up the shortfall on a daily basis.

Inspectors found that there were insufficient staff on duty across the centre. This inspection was unannounced and on arrival to one location an unqualified volunteer was alone supervising 3 residents with complex needs. Inspectors were aware that COVID-19 testing was occurring on the day of inspection, a staff member and house coordinator arrived to this house to support the volunteer approximately 25 minutes after the inspector arrived. Documentation reviewed regarding these residents indicated that some of these residents also had active safeguarding plans and risk assessments in place due to their assessed support needs.

Staff members spoken with told the inspector that there was not enough staffing support and they were working very hard to provide a good service for residents but the service was under pressure due to a deficit in staffing and levels of resourcing. Staff spoken with highlighted keeping the centre clean was too difficult given the size of the centre. In another house a staff member outlined that at night one volunteer always provided sleeping cover to support a staff member who was on a waking night shift. However, as one of the residents was assessed for one to one staff support this placed ongoing responsibility on the volunteer. On reviewing meeting minutes the volunteers were recorded expressing their concern that they also had responsibility for an epilepsy seizure alarm at night which meant they were often disturbed.

The person in charge outlined at the commencement of inspection that the staffing levels were not appropriate and the centre's over reliance on volunteers (as cited on the previous inspection) continued to be a problem. Inspectors were also informed of upcoming planned industrial action and staff work stoppages in the centre.

A sample of Schedule 2 files was reviewed by inspectors and while they contained the majority of information required by the regulations inspectors found that 13 documents to ensure that staff are appropriate to work in the centre were missing from the sample reviewed. These included no photographic identification in one file and out of date identification in another, no CV or gaps in employment records in three files.

Judgment: Not compliant

Regulation 16: Training and staff development

While training had been provided to staff in key areas such as infection prevention and control requirements, the inspector observed staff practices and hygiene records and found that management were failing to ensure that this training was being implemented. In addition, four staff had not been provided with mandatory training in behaviour management and eight staff were due refresher training in line with the provider's policies. Organisational policy stated that formal staff supervisions were required every two months. The inspectors reviewed staff records and found that supervision meetings were not taking place as outlined in the provider's policy, for one staff no supervision records were found from 2019 to 2021 and for another records for a different staff member were found in their file. The person in charge highlighted only a very small percentage of staff had any formal qualifications/courses completed. Some staff had not been provided with important training updates in line with the provider’s policy. The management team and person in charge were failing to ensure that key training was implemented by staff such as safeguarding, fire safety, infection control, and safe administration of medication.

Judgment: Not compliant

Regulation 23: Governance and management

Governance and management of this centre was found to be poor. Where serious issues were impacting on the quality of life for residents steps had not been taken to identify or address these issues.

While inspectors acknowledge that initial implementation of new systems had begun these measures had not led to the required improvements. There was a disconnect between management oversight and the delivery of care and support to residents based on the findings of this inspection.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Residents' contracts were reviewed. These are important documents setting out the service to be provided to residents in addition to fees that may be charged. Of those reviewed however two contracts had an incorrect amount recorded for the charges residents paid for services and amenities.

Judgment: Substantially compliant

Quality and safety

The person in charge and the staff team in the centre were trying to ensure that most residents were in receipt of a safe service. Inspectors noted that some of the residents they met with, presented as reasonably well cared for on the day of inspection. However, this was not consistently the case for all residents due to the under resourcing of the centre, and the poor standard of monitoring, supervision and oversight of care and support.

Inspectors found that overall, the premises were in a poor state of repair and upkeep, with the extremely poor condition of one area of the centre presenting a risk which could be viewed as neglect or a safeguarding issue. In addition, inspectors found that there were poor infection control practices in the centre.

This centre comprises of seven residential units located in six houses a rural setting. Notwithstanding the very neglectful living conditions found in one part of this centre the premises overall presented as requiring substantive maintenance, cleaning and repair in the locations inspected. Staff reported difficulties with cleaning such large premises and inspectors found parts of premises that were not clean or ventilated. Damp was also found in some part of the premises also.

The registered provider failed to protect residents from all forms of abuse. In addition, to the above mentioned neglectful living conditions found, inspectors were not satisfied that appropriate safeguarding practices were in place. For example, some safeguarding plans were in place but not consistently implemented, some safeguarding actions were not followed up in a timely manner and some safeguarding concerns were simply not being identified by the provider at all.

In terms of prevention against infection, inspectors observed some practices that did not comply with public health guidance during a public health emergency. For example, the provision of clean and hygienic living environments for residents and appropriate staff use of Personal Protective Equipment (PPE).

While some improvements were noted since the centre's previous inspection with regards to the systems in place for the management and protection of residents finances. It was observed however that staff were still referring to the old 2017 policy on managing finance which was present in all resident files. Inspectors saw that while a lot of work had been completed by the provider in engaging with residents' representatives, some residents still did not have full access to their

money and as a result the provider did not fully oversee or audit the residents' finances in line with their policy. A review of resident cash balances on the day of inspection found that they tallied correctly. However the security arrangements of residents' finances required improvement as the accessibility to residents' monies was not found to be secure.

Risk was not found to be appropriately managed in this centre. Inspectors could see efforts had been made on the part of the provider to try to move towards a better system of risk oversight and management since the previous inspection. The Quality and Safety lead gave a review of the risk register and all risks and safeguarding matters in the centre from their perspective. This included, the commencement of an updated risk framework and risk register and the reporting and documentation structures around same. However, the recorded control measures in place and action taken for some risks were either not in place or ineffective based on inspection findings.

Regulation 12: Personal possessions

Staff continued to refer to the old 2017 policy on managing finance which was present in all resident files. The provider had not ensured that the revised and updated policy had been implemented in the centre. In addition, some residents still did not have full access to their money and as a result the provider did not fully oversee or audit the residents' finances in line with their policy.

While a review of resident cash balances on the day of inspection found that they tallied correctly the security arrangements of residents' finances required improvement as the accessibility to residents' monies was not found to be secure.

Judgment: Not compliant

Regulation 17: Premises

The houses comprising this designated centre all required maintenance both internally and externally in terms of suitability, layout, accessibility, redecoration and cleanliness.

While parts of the centre were found to be warm, staff reported significant issues with the central heating systems across the centre buildings which the person in charge corroborated. Inspectors were told this had been repaired but was under continual review. An active safeguarding plan reviewed related to a resident feeling cold at night in one location. Staff spoken with indicated certain locations/buildings as worse than others in terms of heating and cited this as an ongoing matter. The toilets, bathrooms water and plumbing in the centre were found to be in poor order. Bathrooms were not clean, were poorly located or not accessible or were in poor

maintenance order and needed to be replaced/re-fitted/re-tiled. Water pressure in some taps was very poor with either lime or silt clogging the water supply on a number of taps/showers. Some residents showers were seen to be out of order (with inspectors told they preferred a bath) and other residents who favoured showers over baths were found not to have access to same. On turning on taps in one resident's bathroom the water was dark brown in colour. Having reported concern with same the inspector was told that this bathroom was not used (it was located beside one residents' room and adjacent to another's and the bathroom door was open). The provider had previous issues with water contamination with contaminants found in the water supply in this centre being notified to the Chief Inspector on 2 September 2020. Inspectors were informed that a series of water testing and corrective actions were in place and the water was currently safe for drinking and resident use.

Judgment: Not compliant

Regulation 26: Risk management procedures

Urgent action was issued regarding this regulation. The conditions in one living area posed high levels of risk to health and wellbeing.

Furthermore, a bottle of the resident's medication was observed on the floor beside an animal's feeding bowl. Food items were also being stored in this area which the resident had been eating, in addition food items being present in their toilet/bathroom.

The registered provider did not ensure that systems were implemented in the designated centre for the assessment management and ongoing review of risk, including a system for responding to emergencies

For example there were 13 risks (risk rated orange by the provider) after the control measures were applied.

These were found to be (in the majority) key areas for the basic provision of care and support to the residents. For example:

- Risk of harm to residents due to staff errors and omissions when in the care of Camphill Community Duffcarrig.

- Risks due to insufficient resources to provide the required support to residents in Camphill Community Duffcarrig.

- Risk of injury to residents or loss of personal property.

- Risk of failure to comply with regulatory standards due to infrastructural deficits.

- Risk of non-compliance with regulatory standards due to inability to recruit and

retain staff with the required skill set and qualifications.

- Risk of consuming contaminated well water.

Inspectors found/witnessed risks on this inspection regarding all of the above areas in addition to other areas such as environmental risk.

The inspection of this centre found that while some risks were being identified and escalated to a better standard than on the previous inspection, other risks (some very serious) were not being identified at all. For example, resident welfare and protection, resourcing/staffing, health and safety, environmental risks. The provider had mapped out new risk documentation and reporting systems for risk management. However unless this approach is fully understood by all staff, supervised by management and embedded and implemented at operational centre level, this does not constitute effective risk management.

Judgment: Not compliant

Regulation 27: Protection against infection

Inspectors observed practices that did not comply with public health guidance during a public health emergency. This was in addition to the serious findings in one part of the centre whereby living conditions observed were not found be clean, hygienic or ventilated.

Some staff were observed wearing masks and using hand gels which were seen to be readily available. However staff face mask usage was not apparent on the morning of this unannounced inspection, but improved in the afternoon when inspectors were moving around the grounds. While some of the houses visited were clean and there were cleaning schedules in place and being followed, this was not the case for all locations. In all houses there was a single point of entry, with hand washing sinks available, in one house the bins for the disposal of hand towels were not operating effectively via the foot pedal to open.

Judgment: Not compliant

Regulation 28: Fire precautions

Urgent action was issued regarding this regulation. Inspectors found that evacuation drills had not been completed in one living area and there was increased concern about risk of fire and ability to evacuate from this area given the extremely poor physical state of the living environment with clutter blocking passage through the environment.

Judgment: Not compliant

Regulation 8: Protection

Urgent action was issued regarding this regulation. The living conditions in one area were so poor that they could constitute neglect and a safeguarding issue. Following this inspection the inspection, the inspectors made safeguarding referrals to An Garda Síochána and to the National Safeguarding Office of the Health Service Executive (HSE).

The registered provider failed to protect residents from all forms of abuse. In addition, to the above mentioned neglectful living conditions, there were nine open/active safeguarding incidents of alleged peer to peer abuse, neglect, sexual abuse and financial abuse and these were reviewed. While safeguarding plans were in place and inspectors found no apparent/reported current risks to residents based on the documentation reviewed, some of these matters were open since 2018 and 2019 respectively without conclusion. Furthermore there was an inconsistency in approach to safeguarding. For example one case was being treated as a financial safeguarding matter while another case with very similar information was not treated as a financial safeguarding matter. A resident was also observed by inspectors as not to have been appropriately supported with their personal and intimate care which did not ensure their dignity was upheld.

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	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Camphill Community Duffcarrig OSV-0003610

Inspection ID: MON-0031662

Date of inspection: 02/03/2021

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: 1. CcoI recognise that a different organisational structure is required to ensure governance and oversight at community level. CCOI intend to restructure Duffcarrig with 3 designated centres, with the 3 Pics' directly managing the social care workers and staff teams within 2 houses each. These PIC's will be managed by a Services Manager who will manage service delivery across the communities of Duffcarrig and Ballymoney. CCoI will eliminate the role of House Co-ordinator and Quality & Safety Co-ordinator in these communities. 2. CCoI will commence the process of submitting new registration documentation for 3 designated centres mid-April 2021. 3. The interim structure outlined below has evidenced the requirement for the PIC to be closer to the community member and the team who support them. CCoI are proposing a new community structure to ensure the required governance and oversight is in place to ensure safe and effective services with 3 PIC's and one Services Manager.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Recruitment has been progressed for new staff to strengthen the skill mix across the community and to be deployed to replace short term co-workers and strengthen the skill mix across the community. New staff have been onboarded to date and staff from other communities have been redeployed to support the service in the interim period.	

2. The use of agency was assessed at 3.4 WTE on 12th March 2021. CCoI is targeting the replacement of all agency staff on the roster through the recruitment of core staff and the creation of a relief panel to support absences. Rolling recruitment will continue until consistent staffing and relief panels are in place. Advertising will place on multiple platforms.
3. Comprehensive review of staffing requirements against the assessed needs of the Community Members has been completed by CCoI, who are actively engaging with the HSE for the resources required.
4. Full review and restructuring of Schedule 2 files were completed by CCOI's national HR team by 15th March 2021. Each file has been completely restructured; gaps in documentation are being addressed with each staff member, progress is being tracked daily with the HR and operations teams.
5. A review of the role of Duffcarrig STCW's roles, responsibilities rosters, and training provision to date was completed on 17th March 2021. New staff will be allocated to ensure that STCW's are supported appropriately.
6. CcoI have completed a comprehensive national review of the Short-term Coworker model during 2021, the future strategy will utilize the international volunteers as an important part of their life sharing model, but reduce their hours of work and their role will be limited to supporting community members with meaningful participation and engagement, the outcomes of CCoI's resource allocation project
7. and the WTE requirements reflect an increase of core staff to reduce the dependency on volunteers.
8. CcoI are engaged in a conciliation process with SIPTU to resolve the industrial relations issues and is chaired by an independent arbitrator from the WRC. Planned industrial action has been deferred. The first meeting commenced on 25th March 2021, with a weekly engagement scheduled for the duration of the 4-week conciliation talks.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. To address the deficits in care and support at house level, an interim service restructuring has taken place with increased oversight at house level by 3 Team Leads who are assigned to support 2 houses each. They complete daily visual inspections, directly supporting the development of good practice with the frontline teams, identify areas for improvement and are working intensively to embed a standard range of CCoI processes to evidence person centred care and support, and ensure heightened governance at house level.
2. By 1/4/21 the following additional training will have been provided to staff
a. HIQA standards and the role of the social care professional,
b. food safety
c. management of fire registers,
d. safeguarding,

e. medication management
f. complaints management
g. training in the policy and SOP for the management of Community members finances and personal possessions.
3. Further training is planned in applied safeguarding, behavioural support, report writing and restrictive practices to be completed by end of May 2021.
4. Training schedules have been reviewed and mandatory training requirements will be scheduled for all staff by 31st May 2021.
5. A review of the qualifications standards of staff was completed by the HR team on 15th March, A HR process is being commenced withal staff where gaps in qualifications are outstanding to ensure that appropriate qualifications are completed within the shortest possible timeframe and in line with the grandfather rule.
All house Co-ordinators have been scheduled for supervision, and all outstanding supervisions will be completed by 16th April 2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The CCoI Head of Services has assumed an active management role in this community until the successful restructuring has been achieved.
2. As an urgent action the existing management structure was reviewed, and an interim management structure was put in place from 15th March 2021. The team include the interim PIC with skill and experience in achieving compliance, 3 Team Leads and a designated clinical support officer.
3. The duties and responsibilities of the Quality and Safety Co-ordinator have been subsumed into the team lead role in each of their houses. In this way additional and consistent governance and oversight resources have been deployed at the point of care delivery in all of the houses and for all community members.
4. The 3 Team leads provide direct support, monitoring, and oversight for 2 houses each completing visual inspections daily, support the development of good practice with the frontline teams, and are working intensively to embed a standard range of CCoI processes to evidence person centred care and support, and ensure heightened governance at house level. The Team Leads ensure that each Community Member with support needs have their weekly schedule of planned supports and meaningful engagement delivered by the teams who support them through their daily checks and supports to the team.
5. The local management team at Duffcarrig have a daily meeting to review the previous days actions, track progress, identity and action areas for improvement in line with a targeted work plan. Reports arising from these meetings are shared with the Head of Services.
6. Weekly review meetings are chaired by the Head of Services and involve the local management team, heads of function, members of the clinical and safeguarding teams,

to share progress, track actions completed for the previous week, agree a workplan for the week ahead.
In line with the National Provider Assurance plan a dynamic Improvement Plan will be created for this community to integrate the findings and actions from the unannounced inspections, annual reviews, and audits into a single management tool. Progress is tracked on this tool and will be reviewed on a monthly basis with the PIC as part of their supervision. information will be shared with the team and actions assigned at community management meetings.

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:
1. A full audit of CMSN contracts commenced on 31/3/21, any incorrect amounts recorded will be identified and addressed by 9th April 2021.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
1. Team leads check the reconciliation of CMSN's accounts against personal finance form, daily logs and cash on hand daily.
2. Training has been provided for the Duffcarrig House Co-Ordinator's in the new policy and SOP on 16/3/21 and 23/3/21.
3. Team Leads have overseen the updating of the Money Management Assessments and Plans per CMSN and Personal Asset Registers using the templates for the new CMSN finance policy all documents will be completed by 5th April 2021.
4. Efforts to reduce the restrictions on the access of 3 community members to their bank accounts have been progressed since the date of the inspection, a repeat functional assessment will be completed on 15th April 2021 by the banks and supports are being provided to the CMSN's to prepare them for the assessment.
5. Engagement continues with families to facilitate CMSN's to have control over their finances. (see regulation 8 feedback below)
6. The security arrangements of resident's finances have been reviewed, access to areas where residents finances are stored are restricted and a visual inspection has taken place of these arrangements on 28th March 2021, confirming that improvement has taken place, team leads are monitoring this daily. Key working sessions are being progressed to support CMSN's who like to retain some money themselves.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Funding for a new heating system has been confirmed by the HSE and is being sourced. At present back up oil system being used; no issues are being reported currently.
2. Full programme of premises and maintenance upgrades underway for each house a schedule of works is available for review.
3. External contractors have completed a deep clean in each of the houses.
4. Following an inspection of the houses all necessary upgrades of furniture and soft furnishings have been provided for the comfort of the community members with support needs.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. Immediate Actions were completed at Francis House apartment.
2. House Co-ordinator ensures the schedule of cleaning has been completed with daily oversight by the assigned Team Lead.
3. Key working sessions and supports are being provided to the CMSN who lives in Francis Apt to support her with the additional presence of staff in her Apt to carry out regular cleaning.
4. An independent systems review has been commissioned by CcoI to review the factors which caused the failure to meet compliance at Duffcarrig.
5. A full review of the risk register was completed by the Safety & Risk Manager and PIC on 29/3/21 and Head of Services, all control measures were reviewed, consideration was given to the risks identified by this inspections and control measures and risk ratings are being reviewed to reflect these outcomes.
6. Training in risk management will be provided to all staff by 31st May 2021.
7. Improvements have been made in same day reporting, through the setup of a Duffcarrig management group email account on 17 March 2021.
8. Risk registers and quality and safety incidents are being reviewed and updated monthly at Community Management meetings.
9. The progress, management and oversight of the required mitigations, control measures and follow up actions are assigned and reported on through this forum monthly.

10. The team leads are supporting the development of good practice, monitoring and overseeing its implementation at house level.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. Immediate Actions completed at Francis House apartment, schedule of cleaning in place with daily oversight by assigned Team Lead.
2. Staff were reminded of the requirements for the wearing of masks by the Head of Services at a staff meeting of 15th March 2021. They were advised that a zero-tolerance approach would be taken for the protection and welfare of all CMSN, s and staff.
3. Daily oversight by the Team Leads and the PIC have ensured improvements in mask wearing across the community.
4. A new standard cleaning schedule is in place across the community with daily oversight by the assigned Team Leads.
5. An external contractor has completed a deep clean in each house.
6. New bins have been provided where required.
7. Gaps in mandatory training to be scheduled by 30th April 2021.
8. Training for all staff in risk management, to be sourced and delivered by 31st May 2021.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. CcoI Safety & Risk Manager conducted a review of fire drills and fire registers at Duffcarrig on 12th March 2021 an audit report and action plan was created and a repeat audit to completed by 12th April 2021.
2. Training provided to the House Co-ordinators by Safety & Risk Manager on 30/3/21 on the maintenance and management of fire registers.
3. A fire drill has taken place 3/3/21 which resulted in a safe evacuation of the Francis Apt CMSN's within 2 minutes
4. The internal audit team have identified on 3/3/21 that 2 evacuation drills were completed in 2020 for Francis Apt.
5. Full review of PEEPs will be completed by 30th April 2021

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The assigned team lead for this house is providing direct support, monitoring, and oversight for Francis house completing visual inspections daily to ensure that service standards are being met.
2. A review meeting has been held with CCoI Safeguarding team on 31/3/21 to review all open cases and to agree an action plan for all open cases.
3. Applied safeguarding training has been scheduled for all staff at Duffcarrig, 16 dates in total from 13th to 23rd April 2021 to ensure that staff at house level are provided with a comprehensive understanding of the CMSN's safeguarding plan and their roles and responsibilities in the delivery of those plans.
4. All issues related to CMSN finances are being overseen by a national group, which reviews each case and supports the PIC with the actioning of next steps. This group supports the PIC to action for each case, i.e. a progression to safeguarding, advocacy services, dept of social protection, or a restrictive practice as where financial institutions impose restrictions on CMSN's access to their bank accounts. The outcomes of this work is reported to HIQA as part of the National Provider Assurance programme.
5. The Head of Services is also sitting on a national HSE Community Operations subgroup for PPPG Subgroup Resident's personal property, personal finances, and possessions, which aims to develop National Guiding Principles in relation to "Resident's personal property, personal finances and possessions" for Disability Services, the learning will be applied to CCoI to ensure that each CMSN has the maximum security and control over their personal finances and personal possessions.
The intimate care policy and SOP's will be discussed at the Community management meetings and House meetings on 6th April 2021. The team lead attached to each house will observe and improve practice through instruction, support and monitoring

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	30/04/2021
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/06/2021
Regulation 15(1)	The registered provider shall	Not Compliant	Orange	30/06/2021

	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.			
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.	Not Compliant	Orange	30/06/2021
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	31/05/2021
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.	Not Compliant	Orange	30/06/2021
Regulation 16(1)(b)	The person in charge shall	Not Compliant	Orange	09/04/2021

	ensure that staff are appropriately supervised.			
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	30/06/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/04/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2021
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	15/03/2021
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	Not Compliant	Orange	31/05/2021

	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.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	15/03/2021
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	09/04/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Not Compliant	Red	03/03/2021

	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	31/05/2021
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	Red	03/03/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	03/03/2021
Regulation 08(6)	The person in charge shall have safeguarding measures in place	Not Compliant	Orange	16/04/2021

	to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.			