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:	26 May 2021
Centre ID:	OSV-0003610
Fieldwork ID:	MON-0032377

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
Wednesday 26 May 2021	11:00hrs to 17:50hrs	Tanya Brady	Lead
Thursday 27 May 2021	10:00hrs to 17:30hrs	Tanya Brady	Lead
Wednesday 26 May 2021	11:00hrs to 17:50hrs	Conan O'Hara	Support
Thursday 27 May 2021	10:00hrs to 17:30hrs	Conan O'Hara	Support
Wednesday 26 May 2021	11:00hrs to 17:50hrs	Conor Brady	Support
Thursday 27 May 2021	10:00hrs to 17:30hrs	Conor Brady	Support
Wednesday 26 May 2021	11:00hrs to 17:50hrs	Louise Griffin	Support
Thursday 27 May 2021	10:00hrs to 15:30hrs	Louise Griffin	Support

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic and was completed over two days. It involved four inspectorate staff, ensuring all seven locations that make up this designated centre could be visited, while adhering to public health guidance and national best practice relating to infection prevention and control. A full documentation review was completed in an office space separate to residents' homes over the two day unannounced inspection. Inspectors also reviewed notifications of incidents submitted by the provider and information received through HIQA's Concerns Helpdesk, including a referral from the HSE's Confidential Recipient.

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. Following the most recent inspection in March 2021, when inspectors found very poor living conditions for residents, on this inspection the provider had made improvements to the premises, particularly the areas of the centre that had been in a very poor state of repair and upkeep. However, inspectors also observed residents continuing to live in conditions that were not of a standard that they were entitled to and further improvements were required in such areas as residents' bathrooms. The provider stated that these improvements were dependent on funding being made available.

There were 23 residents living in the centre and inspectors met all of the residents present in the centre over the two days of inspection. Inspectors also met with 23 members of staff, three short term co-workers (volunteers) and members of the senior management team. In addition, the inspectors requested that the registered provider inform all resident families and/or resident representatives that this inspection was taking place. Inspectors spoke to eight families at their request by telephone both during and immediately following the inspection and received written email correspondence from another family member.

Inspectors received a mixed response regarding this centre from both residents and families. Some residents communicated verbally and very articulately expressed their views while other residents communicated non-verbally through behaviours, gestures or facial expression. Inspectors also observed the day to day life of residents during the inspection.

Residents told the inspectors of their experiences. Some residents said they were happy living in the centre while other residents said that there were a number of things that they were very unhappy about. While some residents were observed engaging in activities such as going for walks around the centre or returning from horse riding, other residents had very little to do during the day. Some residents told inspectors that they had nothing to do in the centre and some were observed to spend most of the day inside watching television despite it being warm and sunny out. Following the previous inspection, the provider had identified this as an area for

improvement and some steps had been taken to begin to improve this engagement.

Residents told inspectors that they were unhappy with the number of changes being made in the centre which had not been discussed with them, and were also unhappy with the frequent staff and management changes in the centre and how this impacted on their daily lives. For example, inspectors met one resident who had plans for the morning but the volunteer who had been identified to support them did not turn up and the resident had not been told. While inspectors found that staff were warm and friendly with residents, new staff and agency staff were not provided with adequate induction which meant that some aspects of support observed on the previous inspection had ceased, such as the use of staff photographs and symbols to assist residents to communicate or to make sense of their day.

While some families said that they were satisfied with the service, others were very critical of management in the centre and referenced the failure to improve services for residents. Families said that the provider had not communicated with them adequately and that there had been a number of changes made in the centre without consultation with residents or families. Other areas of concern expressed by families included a family who was concerned about the impact of the ongoing industrial action on the centre. Another family expressed concerns that residents had been exposed to Gardaí being called to intervene in a dispute between staff and management in the centre, which was confirmed by the person in charge and reported in the local media. Some families spoke positively about the provider's 'old ethos' but were concerned with frequent changes in the centre and poor communication from the provider. Another family member clearly articulated a deterioration in the care and quality of service provision and also highlighted communication with families as very poor.

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

Capacity and capability

Following a series of very poor inspection findings in centres operated by Camphill Communities of Ireland throughout 2020, the registered provider was required to submit a comprehensive national improvement plan to the Chief Inspector of Social Services in October 2020. It started in November 2020 and came to a conclusion in April 2021. The implementation of the national plan was monitored by the Chief Inspector of Social Services on a monthly basis. This centre was last inspected in March 2021 as part of this national monitoring programme of Camphill Communities of Ireland and inspectors found that the provider had failed to implement improvements for residents in the centre during the implementation of their national plan. Inspectors found high levels of non-compliance impacting on the quality of

service being provided to residents. In particular, some areas where residents lived were very unhygienic and were in a very poor state of repair.

Following the March 2021 inspection, the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of the centre. As is their right under the Health Act 2007, as amended, Camphill Communities of Ireland submitted formal representation to the Chief Inspector setting out why the centre's registration should not be cancelled and outlining their proposed actions to come into compliance with the regulations. However, the provider subsequently emailed the inspectors to inform them of changes to important actions in their original representation which indicated a less robust approach to their improvement plan for the centre.

Overall, this inspection found that the registered provider had failed to demonstrate the necessary level of improvements in the provision of safe and quality care required for residents in this centre. While the inspectors acknowledge that some changes had been made by the registered provider in the weeks preceding the inspection, particularly in relation to improvements to the premises, the provider did not fully demonstrate an ability to implement the actions set out in their own national improvement plan, their representation to the notice of proposed decision and improvement plans submitted following previous inspections.

There had been another complete change in the local management team since the inspection in March 2021, the team in place at that inspection had also been newly appointed at that time. The provider had begun to implement a number of additional changes including the restructuring of the management of specific houses moving from house co-ordinators in each house to the appointment of three team leaders who were responsible for specific groups of houses within the centre.

The provider had completed an audit of the service following the last inspection which had identified further residents living in unhygienic and poor living conditions and residents who were poorly occupied and engaged. An action plan was developed as an outcome of this audit and a repeat audit was scheduled for the week following this inspection. Inspectors noted that changes to auditing and management structures have occurred following every inspection of this centre since 2018 and are outlined in the provider's compliance plans contained in previous inspection reports. However inspectors have found that the provider has continuously remained in a place of auditing and 'problem identification' and has failed to move into 'problem solution' position of governance. For example in the areas of risk management and safeguarding.

There were regular meetings both at management level and with staff teams and minutes from these were reviewed by inspectors. It was of concern to inspectors that the actions identified by the provider at these meetings were not being completed as planned. The provider stated that this was usually as a result of insufficient resources.

The registered provider had submitted an updated assessment of staffing requirements for this centre based on residents' assessed needs to the Chief

Inspector as part of their National Assurance Plan. Inspectors found that staffing arrangements remained a concern in this centre with poor levels of staff provision, staff consistency and staff induction and staff training found.

Regulation 15: Staffing

Inspectors were concerned with the numbers, skill mix and consistency of staffing provision in this centre. Of particular concern was the inconsistency of staffing and the impact this was having on support to residents. The provider informed inspectors that the assessed staffing levels required in the centre was 43 staff, and that they currently had 35 staff. The provider used considerable agency staff and volunteers to achieve their staffing levels to provide supervision, care and support to residents. Temporary secondment of staff from other centres and from the funder (Health Service Executive) had been in place briefly but at the time of inspection, these secondments had finished.

The inspectors found that staffing levels were not being determined by the assessed needs of the residents. For example, in one house staffing levels had been reduced, removing one to one support for residents. This was despite a resident's assessment of need and individual care plans which identified them as requiring their own one to one staff support. There was no review or updating of assessments provided as a reason for the reduction in their staffing levels. Previous provider commitments regarding staffing rosters to improve service provision to residents had not been implemented by this inspection.

Staff arrangements did not enable staff to plan their work and ensure a consistent level of care and support to residents. From a review of rosters, there were frequent staff changes in each house, a heavy reliance on unfamiliar agency staff and volunteers and poor induction and training for staff which impacted on the ability of staff to deliver a good quality service. Up to 50% of the staff team were agency staff and up to 40% of the night cover was provided by volunteers. Agency staff told inspectors that they did not receive instruction or induction when they arrived as new staff in the centre. There were no training or induction records to provide evidence of adequate induction and training, and some residents and families said that they were concerned at the frequency that staff changes were occurring and that families found that these staff were not provided with adequate information about residents.

Other concerns in relation to staffing included staff who spoke with inspectors and said that they did not always know who was going to be working with them. In one house, inspectors met an agency staff member who was there for the first time and was trying to become familiar with residents' information while the other staff member provided all of the support to four residents. In another house the majority of staff were agency, volunteers and a student. Many of the residents' assessments stated that they required the consistent provision of care and support which was not possible given the level of staff changes.

The inspectors reviewed a sample of staff files. The regulations require providers to obtain specific information on all staff and volunteers to ensure that they are suitable to work in a designated centre. This had been included as a priority area for improvement in the provider's six month national improvement plan. Inspectors found that a number of required documents remained absent from the sample reviewed, including out of date identification, details on the position a person holds in the centre, and references. Hence the provider failed to demonstrate that they had sufficient oversight to ensure that staff were appropriately vetted and suitable for working in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The registered provider had given assurances to the Chief Inspector of Social Services regarding the provision of training and the provision of formal supervision to staff following previous inspections of this centre, in the provider's National Assurance Plan and in the recently submitted representation document. The inspectors found that these actions have not been achieved.

Supervision of staff had been highlighted as a continued area of non-compliance and concern since inspections in February 2020 and inspectors found that over half the staff in the centre still did not have appropriate supervision arrangements in place in line with the provider's policy.

In addition, three staff were overdue refresher training in safeguarding, an area of concern that had been identified in previous inspections. Five staff were overdue training in manual handling and two in fire safety with 14 staff due training in positive behavioural support, as required by the provider's own policies. In the area of medication management 12 staff were overdue refresher training, with one scheduled to complete this training in June 2021 and 11 scheduled for November 2021. Inspectors found that individual resident's risk assessments stated that staff should have completed training in positive behaviour support, wheelchair lift training, and in medication management as a risk management measure prior to working with certain residents and this was not happening.

The provider had identified 'food safety' as a priority for staff training and had scheduled this training for June 2021.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors remained concerned that a sustainable governance and management team was not yet in place in this designated centre despite:

- The provider having appointed four different persons in charge since September 2019. This has resulted in inconsistent governance of the centre.

- The provider has made significant governance improvement assurances as part of their National Improvement Plan 2020-2021 and failed to implement the required improvements in this centre.

- The provider has made substantive governance improvement assurances in formal Representation to the Chief Inspector of Social Services and then subsequently communicated changes to key components of this Representation which reduced the impact of their original representation and their ability to implement improvements in the centre.

Following the inspection in March 2021, the registered provider had implemented a complete change in the management team for this centre which was an interim measure pending further proposed changes. In addition, changes were instigated in restructuring the management systems within the individual units that make up this centre. Inspectors spoke with newly appointed shift leaders who stated that the provider had not given them clear information on the new responsibilities that came with this position and they were unclear on their level of accountability.

The provider had completed an audit following the March 2021 inspection that had identified multiple further concerns about the quality of care and support in place for residents. Inspectors reviewed a copy of this and found that actions identified had not all been completed as planned. While it was evident that the provider was completing audits of the service there was no evidence of a review of quality and safety of care that included the residents views and those of their families and/or representatives as required by the regulations.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors found that the provider had not ensured notifications were submitted to the Chief Inspector of Social Services within the required timeframe. In particular this was evident in nine notifications of safeguarding concerns which had not been submitted to the chief inspector within three days as required by the regulations.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Policies and procedures are considered essential for the safe delivery of care to residents and to guide staff in delivering safe and appropriate care. They are about good governance from the provider and require review and updating to ensure they are adapted to the service to reflect current practice. This was an area for improvement identified as a priority by the provider in their compliance plans throughout 2020 and in their national governance improvement plan.

The inspectors found that while the provider had made progress within this area, it was still incomplete and had not been completed in line with the provider's own time frames.

Judgment: Not compliant

Quality and safety

On this inspection, inspectors found that the registered provider continued to remain non-compliant in all regulations reviewed.

While inspectors could see that the provider was attempting to improve the quality and safety of the service, there were significant difficulties meeting the basic needs of residents in a consistent manner and there continued to be non-compliances in meeting the assessed support and care needs of residents. Individual support plans were not being updated and were not being used to inform the delivery of care and support.

The inspectors found that while remedial works had been carried out on residents' homes following the very poor findings of inspectors on the March 2021 inspection, these works were not fully completed. In addition the provider had identified further fire safety works required to the premises which were not yet scheduled for completion. This centre was very large and required significant oversight and maintenance.

The registered provider had reported that there had been an emphasis on safeguarding in the centre since the previous inspection which highlighted serious concerns in the centre, inspectors found that the provider continued to fail to implement their own safeguarding procedures to reduce the risk of abuse for residents.

Regulation 12: Personal possessions

Management of residents' finances was non-compliant in both July 2020 and March 2021 inspections and was a central feature of the provider's national improvement plan. On this inspection, inspectors found that some residents continued to have a lack of access and control over their own personal money. Inspectors found that the provider was not ensuring adherence to their own policies and procedures in terms of residents finances.

For example, inspectors saw where a resident's personal money was being kept in the provider's company account rather than in an account in the resident's own name. In another example, inspectors read a risk assessment which contained measures to prevent the risk of financial abuse including a specified limit of the amount of personal money to be kept by residents. Inspectors saw a resident with five times that amount in their wallet. While staff explained that the resident was planning to buy clothes with the money, inspectors found that the money had been withdrawn from the residents account 19 days beforehand.

Other residents continued to be reliant on others to provide access to their money and had minimal or no access to their own money themselves. For these residents the provider was unable to support residents to ensure oversight or reconciliation of the residents' finances.

A family member also expressed concern to inspectors regarding bringing large sums of cash to the centre, some of which had been requested by staff in 2020 and not being provided with a receipt for same. When questioned about this by inspectors the provider undertook an internal review and provided further evidence to inspectors 4 days after the inspection. However some of this included evidence that was dated after the inspection. The provider confirmed a large sum of money had been brought to the centre and accepted that there was no process in place to provide a receipt to the family. However evidence that the monies were lodged to an account in the residents name was provided to inspectors. The provider subsequently stated that they had issued a receipt to the family following the inspection and stated that they had receipts for all of the expenditure.

Judgment: Not compliant

Regulation 17: Premises

Inspectors remained concerned with the standard and quality of the premises. Furthermore given the very large and substantive grounds in this centre, continued maintenance and upkeep both internally and externally is required for which the provider did not have a clear resourced plan in place.

On this inspection inspectors acknowledged the immediate and urgent changes that had been implemented since the March 2021 inspection to both the cleanliness and

decor of much of the internal premises. There were areas however, as identified by the provider such as bathrooms that were stated to be 'unsuitable and not fit for purpose' and in one house the kitchen was stated to be 'not fit for purpose'. The replacement of these was scheduled for completion but the provider stated that this was resource dependent. Residents continued to live with these inadequate facilities at the time of this inspection. Other areas were identified to inspectors by staff as requiring works, such as a shared bathroom in one house that had a strong smell of urine. Staff stated that the smell did not go away with cleaning and this had not been identified for maintenance by the provider.

In one of the houses on the campus, inspectors found that staff had better maintained living arrangements than residents. The inspectors observed in one house that the largest and nicest bedroom which was furnished with a very nice large double bed was for co-workers/volunteer use whilst smaller box style rooms with very modest single beds were in use for residents in the centre.

The provider had compiled a plan to improve the premises as an outcome from their audit following the March 2021 inspection. However, of the eight actions prioritised by the provider for completion in March 2021, three remained outstanding at the time of this inspection. The provider had prioritised 25 actions for completion in April 2021 and 13 of these remain outstanding. The provider has not demonstrated the capacity to deliver on their own improvement initiatives to ensure that the premises meet the residents' needs.

Judgment: Not compliant

Regulation 26: Risk management procedures

While the provider had reviewed their risk management policy since the March 2021 inspection, inspectors reviewed the systems implemented in the centre at this inspection for the assessment, management and ongoing review of risk and they did not provide assurance that they were effective and current.

A risk register was in place that showed 13 risks rated as high risks and each resident had individual risk assessments in place. However, the measures that the provider had identified to manage risks were not being implemented consistently. For example, a number of risk assessments relating to specific residents noted the requirement for staff training as a control measure. However a review of training records found that a number of the staff team were not up-to-date with their medication management refresher training, training in de-escalation and intervention techniques, first aid or wheelchair lift training.

Another high risk on the centre's risk register was around unauthorised visitors to residents' homes and the risk to residents' personal possessions. Inspectors observed an unknown person (later identified as a contractor/maintenance person) walk straight into a resident's home and proceed to go up the stairs without

knocking on the centre's door, ringing a door bell, signing in or identifying themselves to anyone. In another house, access via an accessible unlocked door (identified as a fire escape) was found to lead directly into two residents' bedrooms.

Additionally inspectors found that a risk assessment which was recently reviewed continued to name a previous person in charge as the person with responsibility for ensuring implementation of the risk control measures and was dated three months after this individual had left the centre. Furthermore the registered provider's audits had recommended other risk assessments for residents and these were not available on the day of inspection. Some risks identified as 'minor' on provider risk assessments were in response to significant concerns by families. On further review by inspectors the risk ratings of "minor" were not based on comprehensive and up to date assessment and review of the residents' assessed needs.

Judgment: Not compliant

Regulation 27: Protection against infection

While inspectors observed improvements since the March 2021 inspection with some infection control practices such as staff face mask wearing and hand washing, improvements in a number of other infection control areas were required.

Inspectors found that the waste management system in the centre required urgent review. Large industrial sized bins containing waste were overflowing. Additionally bags of refuse were placed adjacent to bins. The provider and person in charge stated that the waste had not been collected for the last three collection cycles due to a dispute between the provider and the bin company over the alleged inappropriate disposal of personal protective equipment (PPE) in domestic bins. No alternatives had been identified by the provider to ensure residents were not at risk from the presence of multiple large/industrial sized bins and the waste overflow outside their homes. One resident had cut their hand in trying to fit a bag of refuse into one of the overflowing bins as identified in the centre's incident and accident log.

As part of the provider's COVID-19 management arrangements, all staff were to complete specific training for the control and prevention of infection. This had not been completed on the March 2021 inspection. On this inspection, five staff had not completed the training courses. These training gaps did not assure inspectors that the registered provider had taken all necessary steps in relation to infection control in preparation for a possible outbreak of COVID-19.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had implemented a review of the fire precautions within the centre since the last inspection in March 2021 and on the day of this inspection three monthly audits had been completed. While actions had been identified from these audits, inspectors were not assured that these were being implemented or where implemented, that the actions had been sustained.

The provider's fire audit in March 2021 identified that fire drills in a number of the houses seemed to be repeated in the same time period of the day between 13:00 - 15:00 in the afternoon, which does not adequately test or represent evacuation procedures for a 24 hour period. On a review of fire drills in two of the houses, inspectors found that the issue identified in the audit had not been addressed and that all fire drills continued to be carried out in the afternoon. In addition, a sleeping hours fire drill had not been completed in the last year. This had been identified as an immediate risk in the provider's own fire audit in March 2021 and had not been responded to.

Where the provider's audit had identified a high risk for one resident in evacuating, the recommendations for updating personal evacuation plans and personal risk assessments had not been completed. The existing plan would direct unfamiliar staff to use a doorway for evacuation that the resident's evacuation assistive equipment would not fit through.

The March 2021 audit also identified that weekly checks of fire doors, firefighting equipment, emergency lighting and of the fire detection & alarm system were not being regularly completed. While this was recorded as being addressed in the provider's May 2021 audit, a review of the weekly checks by inspectors noted that in a number of the houses on the day of the inspection the weekly checks had not been completed in the last three weeks.

Judgment: Not compliant

Regulation 8: Protection

While there had been some improvements, the safeguarding arrangements found were not effective in protecting residents from the risk of abuse. There was an increase in reported safeguarding concerns in this centre since the last inspection from 11 to 44. While the provider had revised their safeguarding policy and had taken action to better identify safeguarding issues, the provider had not implemented their own safeguarding procedures in relation to all of these issues.

Inspectors reviewed 43 of the safeguarding reports that had been identified and found that the provider had improved their recording and identification of safeguarding issues. Inspectors saw examples of the identification of safeguarding

issues which included such issues as alleged institutional abuse/neglect of residents residing in poor living conditions, peer to peer incidents, and alleged sexual abuse. However inspectors also found instances whereby resident safety and protection was compromised due to the non adherence to the provider's own safeguarding policies and procedures. For example inspectors found an example where a recent serious incident was not reported to management on the date it occurred to enable a speedy response and to protect residents, as required by the provider's own safeguarding policy. Furthermore, inspectors were informed on the inspection that this matter had been investigated. Inspectors requested a copy of the investigation report and it was not furnished to inspectors until the day after the inspection. On review, inspectors found that while the incident had clearly been identified as a safeguarding issue, the provider had not investigated it using the safeguarding policy but had reviewed it as part of the accident and incident procedures.

Inspectors also found another safeguarding investigation had not been concluded by the provider despite being ongoing since 2019 with a further number of other investigations also awaiting commencement at the time of this inspection. In addition, inspectors saw examples of how safeguarding allegations were managed inconsistently in one part of the centre from another part of the centre.

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	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not 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-0032377

Date of inspection: 27/05/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing:	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents:	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions:	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	
Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

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 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	
Regulation 12(4)(c)	The registered provider shall ensure that he or she, or any staff member, shall not pay money belonging to any resident into an account held in a financial institution unless the account is not used by the registered provider in connection with the carrying on or management of the designated	Not Compliant	Orange	

	centre.			
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	
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	
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	
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	Not Compliant	Orange	

	programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	
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	
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Not Compliant	Orange	
Regulation 23(1)(a)	The registered provider shall	Not Compliant	Orange	

	ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures	Not Compliant	Orange	

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation,	Not Compliant	Orange	

	suspected or confirmed, of abuse of any resident.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	