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:	Dunshane Camphill Communities of Ireland
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Short Notice Announced
Date of inspection:	23 November 2020
Centre ID:	OSV-0003616
Fieldwork ID:	MON-0030691

About the designated centre

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

Dunshane Camphill Communities of Ireland is a designated centre that provides 24-hour, seven day residential services on a 52 week cycle each year for 26 residents in a rural location in Co. Kildare. The designated centre consists of eight residential buildings situated on over 20 acres of farming land in a campus style setting. The centre also provides day activation services from 9am to 5pm Monday to Friday, on site. Some residents participate in these day activities, such as baking, cooking, pottery and farming within the grounds of the designated centre or are supported in other interests in the community. The site also contains extensive gardens, walk ways, forest trails, farm land and fields. The centre can accommodate residents of both genders, aged 18 and over with intellectual disabilities, Autism and those with physical and sensory disabilities including epilepsy. Residents are supported by a team of social care workers, care assistants and voluntary workers. In line with the co-living model of care residents share communal living spaces with the volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	19

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
Monday 23 November 2020	09:20hrs to 16:10hrs	Tanya Brady	Lead
Monday 23 November 2020	09:20hrs to 16:10hrs	Marie Byrne	Support
Monday 23 November 2020	09:20hrs to 16:10hrs	Conor Brady	Support

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic and as such all inspectors adhered to national best practice and guidance with respect to infection prevention and control. The inspectors reviewed documentation in an office location and visited three houses (one house each) over the course of the inspection. In total the inspectors met with 15 residents over the course of the day. There were 19 residents in the centre on the day of inspection.

Residents spoken with were complimentary about the service that they received and the staff who supported them. Residents told inspectors they felt safe and well supported. Residents showed inspectors their homes and some proudly showed their rooms, personal plans and gave an insight into what life was like living in the centre. Some residents commented on how they had been negatively impacted by COVID-19 and how they missed going shopping, out for meals and on holidays.

In one of the houses a couple of residents were relaxing in their bedrooms and requested that the inspector did not meet with them and this was respected. Another resident was happy to speak with the inspector and said that they had lived at this centre for a long time but could not remember how long but really liked it. They liked the view of the countryside from their bedroom window and showed the inspector a new mirror they had bought, they explained they had been taken on a trip in the car to go and buy it. Other residents in the same house were relaxing together in the living room and one was dancing to music that was playing in the background. Staff were seen to individually support another resident complete an activity at a table in the living room.

Throughout the day residents were observed walking or completing tasks either on the farm or outside and some came to meet with inspectors in the office space as they wished to have a conversation over the course of the day. Residents had also been supported to have meaningful days during the COVID-19 pandemic, with residents currently continuing to engage in day services albeit in a reduced way. At all times staff were seen to engage warmly with residents, to interact with respect and to adapt their communication style to the individual they were engaging with.

In one of the houses, the inspector met and briefly engaged with three residents living there. On arrival, the inspector was met by the pleasant smell of food coming from the kitchen. One resident who had just finished their lunch greeted the inspector at the door. Two residents were sitting at the kitchen table having their lunch. They appeared to be enjoying their meal.

One resident spoke to the inspector about not being happy living in their home. They talked about things that they didn't like about their current home, such as how noisy it was sometimes. They showed the inspector their transition plan and discussed how staff and their advocate were supporting then to prepare for their move. They showed pictures of how they would like their kitchen to look and things

they would like in their new home. They talked about how excited they were to move to their new home.

One resident showed the inspector an accessible version of their personal plan and talked them through what was important in their life. They talked about how important it was for them to keep busy as they could sometimes get bored easily. They discussed things they liked to do around their home, like cook breakfast and take part in the cleaning and upkeep of their home by doing things like cleaning and hoovering.

Two residents dropped in to visit the inspectors in the office location, during the inspection. One resident came in to talk about how they were feeling during the COVID-19 pandemic and how important it was for them to keep busy and have a routine. Another resident came over to tell the inspectors how good the food was and how safe they felt in their home. They said that staff were very good to them and that their keyworker was very supportive. They talked about how they loved to cook and bake and described things that were important to them like getting out into their local community to go swimming and shopping.

One resident spoke to an inspector about COVID-19. They talked about how important it was to stay safe and follow public health advice during the pandemic. They described the importance of washing your hands regularly, keeping your distance from people and staying close to home. They talked about how important getting out for fresh air was and about how they could go for a nice walk around the farm anytime.

Two residents described how they would safely evacuate their home in the event of an emergency such as a fire. They talked about taking part in fire drills regularly and told the inspector exactly where they would evacuate to in the event of an emergency.

Staff who spoke with the inspectors were knowledgeable in relation to residents' care and support needs, likes, dislikes and preferences. They talked about how important it was for residents to be engaging in activities which were meaningful to them, and how important it was that they stayed in touch with their families and friends during the pandemic.

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, 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 inspection formed part of this national monitoring programme of Camphill Communities of Ireland.

While residents appeared (for the most part) to be happy, content and well supported in their homes, improvements were required by the provider to ensure that all residents were appropriately safeguarded at all times. Issues relating to fire safety were of particular concern. Also the compatibility of a small number of residents and some negative peer to peer interactions had resulted in a number of complaints about the service. However as outlined in the previous section of this report a large cohort of residents also reported to be very happy and told inspectors that they felt safe and well cared for in this centre.

Inspectors were concerned regarding the fire safety arrangements in some parts of this centre. The provider had self identified this fire safety concern as a 'high risk' and highlighted this clearly on their organisational risk register noting the fire safety arrangements in these parts of the centre posed a 'risk of harm to residents and staff of fire related injuries due to inadequate active and passive fire protection..' The provider showed inspectors evidence of engineers reports, risk assessments, health and safety fire reports and costings of the required fire safety works. Evidence of the providers engagement with their funders (the HSE) was also shown to inspectors regarding this matter. However at the time of this inspection the identified fire safety works required had not been completed. Following this inspection, on 2 December 2020 the provider notified the Chief Inspector that they were closing these parts of the centre pending the completion of the required fire safety works.

Regarding resident safeguarding and protection the majority of residents spoken with reported as being very happy and feeling safe in the centre. Residents identified staff who they would speak with if they had a problem or concern and overall inspectors found a good safeguarding culture was apparent in this centre. The person in charge and localised management had good systems in place regarding the response, management, reporting and recording of safeguarding concerns, disclosures or allegations. However in some cases reviewed while the provider had taken some steps to resolve these issues, they were not bringing about the necessary changes to ensure that all residents were happy in the centre. For example, whereby residents were assessed as incompatible, were actively saying they did not want to live with other persons and whereby this was manifesting into safeguarding incidents, further action was required on the part of the provider to address such matters. Regarding financial safeguarding the provider was working towards compliance in this area. While local resident financial cash balances were correct and good local oversight systems were in place, a small number of residents did not have access or oversight to their own bank accounts. There were some concerns highlighted by members of management to inspectors regarding this and this was noted as a continued provider objective in consultation with families in the providers national improvement plan.

The centre had a clearly defined management structure in place consisting of an

experienced person in charge. The person in charge worked on a full-time basis in the organisation and was supported in their role by a full-time and experienced quality and safety lead, house co-ordinators and by a regional manager. The regional manager was present on the day of inspection and met with two of the inspectors. They outlined the changes that been recently introduced since the commencement of the national improvement programme including establishment of community management meetings. To date one meeting had occurred and inspectors reviewed minutes of this. In addition, the regional manager outlined the time they would be on site in the centre and the audits that would be devised and implemented and the formal supervision systems they would be implementing.

Systems were also in place to ensure the centre was monitored and audited. There was an annual review of the quality and safety of care available in the centre along with a six-monthly auditing report and an oversight report which had been completed by an external provider. The last six monthly visit and report had been completed in October 2020, however it was noted that the previous one had been in May 2019. Action plans had been developed in order to ensure improvements arising from the auditing process were addressed in a reasonable time frame. These issues as identified were being addressed at the time of this inspection according to the provider.

Provider level oversight was a crucial component of the national plan to ensure an appropriate connection and demonstrable oversight between provider senior management and individual centres - particularly whereby registered provider level action was required. While some good examples of auditing and provider problem identification was apparent in this centre, the provider response and action to same required improvement. For example, the fire safety findings and incompatibility of residents who in some cases had transition plans completed but had not yet moved.

Staff were provided for the most part with relevant training to assist them in supporting residents. Training provided included, safeguarding of vulnerable adults, fire training, manual handling, positive behavioural support, the safe administration of medication and infection control. However, some staff had not completed training in administration of a required medication for epilepsy even though it was listed as a required control measure in risk assessments for some residents. In addition, some staff were due refresher training in areas such as fire safety and in the management of behaviours that challenge. The quality and safety lead and person in charge had taken steps in relation to staff training to prepare for a possible outbreak of COVID-19. The training records viewed indicated that all staff members and volunteers had completed training in infection control, in donning and doffing of personal protective equipment (PPE) and in hand hygiene.

There was sufficient staff in place to meet the residents needs at the time of this inspection. Two day service staff from the wider organisation had also been deployed to ensure there were sufficient staff in place with one available as a relief staff member. The staff team in this centre were supported by volunteers and on the day of inspection there were 17 of them living and supporting residents with day to day activities and social supports. The provider and person in charge

highlighted that volunteers were only utilised as 'supplementary support' in this centre and were therefore not individually nor primarily accountable for direct care and support of residents. There were no agency staff on the roster for the centre. The provider and person in charge were currently reviewing the current staffing skill mix and whole time equivalent numbers against the residents' assessed needs and this review was scheduled to be completed before the end of the year. Inspectors also reviewed a number of staff personnel files and found that they contained all documents as required by Schedule 2 of the regulations.

The registered provider had ensured the development of a new service provision agreement between the organisation and the residents. This document detailed the services and supports to be provided including any fees to be incurred. This had been an area identified as requiring improvement by both the provider and the Chief Inspector. On review of resident files it was seen that a new service provision contract was in place for all residents, in addition to an easy read version. An implementation plan for the introduction of the new contract was outlined and included one to one conversations in key working sessions. The provider and person in charge explained that they had received eight complaints with respect to changes in one clause relating to resident holidays and these had been fed back to the national consultation group for further discussion.

Regulation 15: Staffing

The provider was undertaking a national review of staffing requirements that was requested but had not yet been submitted to the Chief Inspector. Nonetheless staffing levels and skill mixes reviewed were found to be sufficient on the day of inspection. Good management of staffing and use of resources was found to be in place. The person in charge had good oversight and was very accessible to the team and house coordinators demonstrated good management and leadership of their respective teams.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided for the most part with relevant training to assist them in supporting residents. Training provided included, safeguarding of vulnerable adults, fire training, manual handling, positive behavioural support, basic life support, the safe administration of medication (where required) and infection control. The majority of staff had updated training in place. Some new staff were waiting for provision of training but this had been scheduled and a small number of staff had not completed refresher training in key areas such as fire safety or the management

of behaviours that challenge.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure in place consisting of an experienced person in charge, a quality and safety lead and house coordinators. These demonstrated good local governance and accessible management for residents in terms of care and support. They were also supported by a regional manager who was new to the post in this centre since July 2020. Further improvements were required at this level to ensure the full implementation of provider national commitments and changes were consistently introduced, monitored and reviewed. Some of these changes were in their first month (as was the provider national plan) at the time of this inspection according to the regional manager.

Ongoing issues such as fire safety or ongoing matters adversely affecting residents had been identified by audits however they had not been addressed adequately despite having been identified over a year ago. A number of deficits found were also resource dependant.

There was an annual review of the quality and safety of care available in the centre along with a six-monthly auditing report and an oversight report which had been completed by an external provider. The last six monthly visit and report had been completed in October 2020 however it was noted that the previous one had been in May 2019.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had ensured the development of a new service provision agreement between the organisation and the resident. This document detailed the services and supports to be provided including any fees to be incurred. The new service provision document was in place for all residents on the day of inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector had not been provided with a written report at the end of each quarter in relation to any occasion on which a restrictive practice was used in the designated centre, in line with the requirement of the regulation.

This report had not been submitted for quarter four in 2019.

Judgment: Not compliant

Quality and safety

The quality and safety of care provided to the residents was being monitored and residents' needs were largely being provided for in this centre. Many residents were leading full and meaningful lives and reported being well supported and cared for by staff and management. Residents who had transitioned into this centre from other services had progressed in their lives and done well in this centre. However there were areas that required clear improvements.

The significant fire safety issues that had been identified by the provider and noted by the inspectors on the day were of concern given the risk to residents particularly living in one house. The associated delay in transitioning another resident to their new home also needed to be addressed. This was held up due to lack of completion of fire safety works. In addition ongoing compatibility issues between some residents had resulted in a number of safeguarding issues which were impacting adversely on residents' safety, rights and quality of life. The associated delay in transitioning a resident to their new home needed to be addressed.

The registered provider and person in charge had ensured that control measures were in place to protect against and minimise the risk of infection of COVID-19 to residents and staff working in the centre. There was a single point of entry into the centre. The premises were observed to be clean, there was sufficient access to hand sanitising gels and hand-washing facilities and all staff had adequate access to a range of personal protective equipment (PPE) as required. All staff had received training in this area. Staff temperatures were also taken prior to commencing work. Staff were observed wearing personal protective equipment (PPE) as required by national policy and guidelines. The inspectors witnessed these measures in place throughout the day of the inspection.

There was however no consistent system in place for prevention against some other possible infectious diseases such as legionnaires disease. Houses that were currently unoccupied or bathrooms within houses that were not in use did not have systems in place for maintenance of their water systems and the flushing or running of water and this was of concern as these houses were for resident accommodation. In addition, in one of the houses visited there were bathrooms, surfaces and counters that required cleaning or renovation to ensure effective cleaning could take place.

The inspectors found that while the registered provider had systems in place for the

prevention and detection of fire they had also self identified and risk assessed that two buildings were not safe or effective in terms of fire safety. Inspectors were therefore concerned regarding the overall fire safety of these buildings, fire containment measures, fire retardant materials, open hatches/exposed floors and piping, and absence of emergency lighting in some areas.

Residents had access to health and social care professionals in line with their assessed needs. Residents who required them, had behaviour support plans developed and in place. Staff who spoke with the inspectors were knowledgeable in relation to residents' specific care and support needs. They described the importance of consistency and routines for some residents and told the inspector how important it was for staff to get to know residents and their plans. They talked about the importance for some residents of visual schedules, social stories and opportunities for community inclusion. Staff had access to training to support residents and area-specific training was facilitated as required. However, a number of staff had not completed training or refresher training to support residents in line with their assessed needs.

There were a number of restrictive practices in place in the centre. Residents' personal plans were detailed in relation to the use of these restrictive practices. They were also detailed in the restrictive practice register, which was regularly reviewed and updated. There was evidence that a number of restrictive practices had been removed in the months preceding the inspection. There were regular meetings held to review the use of restrictions in the centre. These reviews included, a review of the rationale for the restrictions, and details of the considerations given to the use of the least restrictive practices for the shortest duration. However, it was documented in a number of residents' plans that they had not consented to the use of restrictive practices. There was a meeting planned after the inspection and a draft document had been produced to look at how best to support residents to make an informed decisions in relation to the use of restrictive practices. This form included considerations in relation to the benefits, risks and implementation of these restrictive practices.

Staff spoken with were knowledgeable regarding processes in place for the management of residents' finances. There were systems in place for the recording of daily expenditure. The inspectors viewed a sample of residents finances and found that records accurately reflected sums of money residents. Residents' personal finances were stored securely and checks and balances were being completed regularly. In addition, financial audits and spot checks were being completed by members of the local management team. For some residents their family members were supporting them to manage their finances. Some residents did not have full access to their money at all times and some had no access to or oversight of their accounts. As a result, staff and the management team supporting residents did not have full oversight of residents' spending and could not complete audits in line with the organisation's policy. The provider was aware of this and in the process of meeting with residents, their representatives and advocates to ensure each resident had access to and control over their money and support to manage their financial affairs.

In addition to a resident telling the inspectors that they were not happy sharing their home with their peers, staff spoke about compatibility issues between residents in two of the houses. They discussed the measures in place to keep each resident living there safe safe, including detailing the measures in safeguarding plans. They acknowledged that they were aware that residents' needs may be better suited in alternative accommodation and described how one resident was regularly vocalising their discontent with their current placement, including discussing it with their keyworker at their regular meetings.

Residents were being supported to make decisions in relation to their care and support and the day-to-day running of the centre. They were meeting with their keyworkers regularly and residents' meetings were also occurring regularly. At these meetings agenda items such as, complaints and concerns, health and safety, safeguarding, community inclusion, visiting, goals and achievements, advocacy, menu planning and maintenance were discussed. Information relating to the complaints procedure, advocacy services, residents' rights and COVID-19 were available for residents in the centre. At one recent meeting, PPE videos, handwashing, cough and sneeze etiquette and social distancing were discussed.

Regulation 12: Personal possessions

Some residents did not have full access to their money at all times and some had no access or oversight of their accounts. As a result, staff and management supporting some residents did not have oversight of the residents' spending or finances. The provider was aware of this and working with residents, their representatives and their advocates to resolve this.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The centre had some very good systems of risk management in place regarding risk identification, assessment, rating and recording. Provider oversight of risk was clearly apparent. However not all risks were found to be appropriately or effectively managed on the day of inspection.

Judgment: Not compliant

Regulation 27: Protection against infection

The person in charge, provider representative and director of care and support had

taken steps in relation to infection control in preparation for a possible outbreak of COVID-19. The person in charge ensured regular cleaning of the premises, sufficient personal protective equipment was available at all times and staff had adequate access to hand-washing facilities and or hand sanitising gels. Mechanisms were in place to monitor staff and residents for any signs of infection.

However some improvement was required in implementing other systems to protect residents from other potential infectious diseases.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had systems in place for the prevention and detection of fire. Fire fighting equipment was present as required and this was serviced quarterly including the fire panels. However in two houses within the centre there were concerns outlined on the day of inspection by the providers own engineers reports and recent fire safety risk assessment. Inspectors were not assured by their observations with respect to the fire safety arrangements in place in these buildings.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Overall, residents were supported by the policies, procedures and practices relating to medicines management in the centre. There were suitable practices in place relating to ordering, receipt, storage and disposal of medicines. However, a number of residents' prescriptions required review to ensure they included the maximum dose in 24 hours for as required medicines.

Medication audits were completed regularly in the centre. Actions were developed with a clear timeframe for there completion. These actions were bringing about improvements in relation to medicines management in the centre.

Residents were being supported following a risk assessment and assessment of capacity to takes responsibility for aspect of the self administration of their medicines.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider and person in charge were promoting a positive approach in responding to behaviours that challenge. Residents had positive behaviour support plans which clearly guided staff to support them to manage their behaviour.

Where restrictive practices were in place, there was evidence that they were reviewed regularly to ensure they were the least restrictive for the shortest duration. However, for a number of residents, it was documented that they had not consented to the use of restrictive practices. The provider had recognised this and following the inspection had plans in place to introduce a new system to document how residents were supported residents to make an informed decision in relation to the use of restrictive practices.

Judgment: Substantially compliant

Regulation 8: Protection

The majority of residents were found to be appropriately safeguarded in this centre at the time of inspection. Of the 19 residents living in the centre four were adversely affected by current active safeguarding concerns. A further three were under current provider review regarding financial safeguarding. The provider reported that there were two cases whereby alleged retrospective abuse (that allegedly occurred in another centre operated by the provider) regarding a resident who moved into this centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were consulted with and participating in the day-to-day management of the centre and making choices in relation to how they wished to spend their time.

Residents' meetings were occurring regularly in the centre and they were kept up to date in relation to the pandemic. COVID-19, the use of PPE, handwashing, social distancing and cough and sneeze etiquette were discussed regularly at these meetings.

there was information available and on display in relation to the availability of advocacy services, and one resident told an inspector about how their advocate was supporting them to transition to another house in line with their wishes and preferences.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dunshane Camphill Communities of Ireland OSV-0003616

Inspection ID: MON-0030691

Date of inspection: 23/11/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Refresher training in Studio 3 (Behavior support) was scheduled for the following dates 10/12/2020 and all staff that required this training completed it on this day. In relation to fire safety and manual handling, all staff identified for refresher training in these areas completed the refresher training on the 30/11/2020 as scheduled. The training tracker is managed and reviewed regularly by the quality and safety coordinator; projected training needs are identified in advance training is sourced of all staff requiring refresher training. Person in charge in line with scheduled audits throughout the year reviews the training tracker as part of the audit process.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Weekly and fortnightly meeting systems will ensure that each CMSNs requirements and preferences will be actioned and any new needs escalated to enhance their quality of life. The regional manager, regional safeguarding lead, and clinical support officer will attend a community management meeting monthly, where they can provide support, and constructive feedback around issues and concerns and communicate these at senior management meetings if required. 2. Regional Manager will attend Dunshane Community fortnightly to check progress on action from Compliance plan and will conduct walk arounds, the regional manager will be available during these visits to offer support and advice to the community. The regional	

will also observe practice within the community and link in with the Person in Charge at regular scheduled supervisions.

3. PIC/ Quality & Safety Officer will complete weekly spot checks and walkarounds/audit where the PIC will select a theme and review the level of compliance required in the management of a designated centre.

4. Regional Clinical Support Officer will attend monthly Management meeting to offer support and oversight with any health issues or behaviors of concern.

5. Regional safeguarding lead will attend monthly Management meeting to ensure comprehensive oversight and support.

6. Schedule of Regulation 23 6 monthly Unannounced Inspections and Annual Review will be completed for Dunshane for 2021 in line with the national compliance plan.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In relation to the responsibility of the person in charge in submitting all required quarterly returns, Human error omitted submitting part of quarter four NF39A 2019 in relation to restrictive practice. The person in charge will ensure all required information pertaining to each notifiable event will be reviewed and submitted as required.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The person in charge in conjunction with the quality and safety coordinator and House Coordinators, continue to engage in a positive process with families of residents who do not have full ownership of their finances, this is ongoing and scheduled meetings have been agreed for January with these families.

Senior management have oversight of the engagement process, which is informed by, and reflected of the revised community members finance policy. Roll out of this policy forms part of the organizational compliance plan and progress on its implementation is monitored on a monthly basis by HIQA as part of the organizational assurance procedure.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The organizational risk management policy has been revised and updated and an operational risk register for the community has been developed and was implemented in late November 2020.
As part of this background work for the community risk register all operational risks

within the community were identified and or reviewed. At the time of the inspection two significant risks were recorded on the operational risk register and were highlighted to the inspectors on the day.
In line with procedures detailed in the updated organizational risk management policy all open risks are reviewed on monthly basis as part of the community management meetings, any risk which is rated 12 or above on the community risk register are escalated to the regional manager and the national risk and health safety coordinator for review.
Both of the significant risks highlighted to the inspectors on the day were under review by the senior management in line with the procedures described above. Arising from this review and as detailed in the Provider Assurance Report submitted on 11/12/20 a series of control measures to address these risks had been implemented to manage and reduce the risks.
Further review of the situation has resulted in closure of one house presenting fire safety risk and the transition of a number of CMSN to suitable alternative placements within CCOI pending fire safety upgrades. These changes have resulted in elimination these 2 significant open risks.

All open risks on the operational risk register for the community will be reviewed on a monthly basis as part of the CMM and open risks rated as 12 or above will be escalated to the regional manager and national risk health & safety coordinator on a monthly basis.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The infection, protection and control policy for the organization was updated and revised at the end of October in line with the organizational action plan. The enhanced procedures for the prevention and control of legionella and other infectious diseases, were introduced in all communities as part of this policy.
Staff have been trained in the implementation of these revised procedures which are now fully operational in the community. Documentation of the necessary checks has been incorporated into the work task of community staff teams.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
As outlined in the provider Assurance report on 11/12/2020 the house where substantial fire safety concerns were identified has been closed. All residents have been supported to transition to suitable alternative accommodation after a consultation period, in line with admissions, discharge and transfer policy of CCOI.

Fire safety upgrade works are being commissioned for two vacant houses and a review of fire safety by a consultant fire engineer has been commissioned to provide further assurance.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The max does for Paracetamol and Buccal Midazolam has been written up on the Kardex, this was rectified on the 23rd of November, following the day of inspection. A communication went out to all House Coordinators regarding the requirement for Max dose to be written on all Kardex's along with detailed information on each protocol.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A review has taken place with the clinical support officer in the community in relation to all restrictive practices, improved systems including consultation of informed consent have been implemented. A draft copy of the new process was shown to the inspector on the day.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: One resident identified as the PACC in two safeguarding cases has successfully been supported to transition to a short term placement in a neighbor Camphill , Building works have been approved and will commence in January to bring the unit up to spec in terms of fire regulation and the residents desired accommodation, fulfilling her long term transition plan to live in a single unit accommodation within the community. The other resident involved in a safeguarding incident is currently in the process of transitioning to another Community within CCoI.	

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.	Substantially Compliant	Yellow	30/04/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/12/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	12/01/2021

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	15/06/2021
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	03/01/2021
Regulation 27	The registered	Substantially	Yellow	03/01/2021

	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.	Compliant		
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	03/01/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	03/01/2021
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency	Not Compliant	Orange	03/01/2021

	lighting.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	03/01/2021
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	23/11/2020
Regulation 31(1)(a)	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: the unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre.	Not Compliant	Orange	03/01/2021
Regulation	The person in	Not Compliant	Orange	03/01/2021

31(3)(a)	charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	31/01/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/04/2021