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 Grangebeg
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Short Notice Announced
Date of inspection:	14 December 2020
Centre ID:	OSV-0003621
Fieldwork ID:	MON-0030690

About the designated centre

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

Grangebeg Camphill Community has a statement of purpose in place highlighting that it is a residential service inspired by Christian ideals where people of all abilities, many with special needs, can live, learn and work with others in healthy social relationships based on mutual care respect and responsibility. The centre is a registered designated centre to provide residential services to up to 13 residents. It consists of two, three storey premises on a campus, on a farm, which is situated in a rural part of Co. Kildare. Staffing support is provided 24 hours a day, seven days a week by a person in charge, social care workers and social care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 14 December 2020	10:00hrs to 16:50hrs	Marie Byrne	Lead
Monday 14 December 2020	10:00hrs to 16:50hrs	Tanya Brady	Support

What residents told us and what inspectors observed

There were ten residents living in the designated centre on the day of the inspection, and the inspectors had the opportunity to meet with seven residents over the course of the inspection. In addition, six residents completed or were supported by staff to complete a residents' questionnaire prior to the inspection.

This inspection took place during the COVID-19 pandemic and as such the 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 the two houses in the designated centre (one house each) over the course of the inspection.

Throughout the inspection, residents appeared content and comfortable in their home, and with the levels of support offered by staff. Residents who spoke with the inspectors told them that they were happy and safe in their home. They were complimentary towards the staff team and the person in charge. A number of residents told the inspectors what was important to them, how they liked to spend their time, and with whom they liked to spend it. They talked about how COVID-19 had impacted on their access to some community based activities and on spending time with their family and friends. However, they also talked about things they were doing in their home, in the garden and on the farm to keep busy.

In one of the houses, the inspector had the opportunity to meet three of the five residents who lived there. One resident was relaxing in the living room listening to two volunteers who were singing and playing the guitar. They smiled at the inspector and then continued to enjoy the music and singing. Another resident who had been relaxing in their bedroom listening to music by their favourite band, came out to seek the support of a staff member, and greeted the inspector. The inspector observed warm, kind and caring interactions between this resident and the staff member during the visit to their home. They talked to the staff member and the inspector about their favourite band, their tablet computer, their favourite shop to buy clothes in, and their plans to decorate their bedroom and other parts of the centre in the 2021. They talked about their favourite possessions and important people in their life, and about how they liked to spend time with them. They also talked about a new neighbour who was renovating their home and how their new neighbour had invited them for a cup of tea, once COVID-19 restrictions were lifted.

Another resident returned from visiting their family while the inspector was visiting their home. They quickly said hello on their way to their bedroom. They were smiling and having a laugh with staff as they walked away. As the inspector was leaving they met this resident again, they had just gotten themselves a drink and were heading off to the living room to spend some time with staff and volunteers.

In the other house, the inspector met with four of the five residents who lived there. One resident was going to the local town for an appointment with a staff member

and stopped to speak with the inspector. They asked if the inspector would mind not looking in their room as they commented it was untidy and the inspector confirmed that they would respect their wishes. Another resident was putting on their boots and coat as they explained they were on their way to the centre farm as they looked after the poultry. They told the inspector about the chicks that were there at the moment and how they had had a visit from a mink recently. The resident explained they also looked after some bee hives and showed the inspector a Christmas wreath they had made. They stated it was lucky they were busy as otherwise the virus would have been very hard if they had had to stay in the house.

Another resident greeted the inspector and asked if they could have a conversation in the sitting room. They told the inspector that they were happy in their home, liked it and the staff. They explained they had a meeting to set their goals later that day and explained what they were going to be. The resident offered to show the inspector around the house and in particular their room which was brightly painted with their own paintings also on the wall. The final resident who met with the inspector had returned from town with a staff member and had bought some wrapping paper for Christmas. They liked to go out and about when it was possible and explained that they also had a meeting coming up soon to set their goals and after that were going to family for Christmas. The resident was supported by staff to have a late lunch in the kitchen.

Residents indicated in the questionnaires they completed prior to the inspection, that they had been living in the centre for between three and ten years. They indicated that overall they were happy with the comfort levels and access to shared areas in the centre, their bedrooms, food and mealtimes, choices, privacy and respect, their safety, access to activities and supports from the staff team. They also indicated that they were aware of the complaints process with some who had used the process saying they were happy with how their complaint was dealt with, with one resident saying ''people listened when I talked to them''.

Residents described activities they liked taking part in, in their questionnaires. These included; gardening, cooking, baking, watching their favourite television programmes, going for walks, shopping for clothes, pottery, drama, arts and crafts, pitch and putt, going out for a meal, and looking after animals on the farm.
A number of residents stated they were enjoying taking part in course such as, literacy, horticulture and baking courses. One resident also indicated that they would like to do a first aid training.

Each residents' questionnaire indicated that they were happy with the support of the staff team. One resident described staff as ''nice'', and another as ''lovely and caring''. Residents included comments such as ''I love living in Camphill'' and, '' I like the views''. Two residents referred to the impact of COVID-19 restrictions on visiting arrangements, with one stating they were unhappy with visiting arrangements during the pandemic and another stating they would like the COVID-19 restriction to be gone.

Residents and their representatives' views had been captured as part of the latest six monthly visit by the provider. In this review, three residents' views were

captured through discussions, and three residents' representatives views were captured by phone. One resident described how happy they were living in the centre. They talked about loving the views and the animals on the farm. They described staff as "wonderful" and said they knew them well and listened to them. Another resident talked about loving working in the garden and on the farm. They described how they were working on a remembrance garden for people who have passed away. They also discussed a goal to develop a sensory garden. A third resident talked about enjoying growing roses and looking after them and working in the polytunnel. One resident stated that a person they lived with was noisy at night time and talked about missing certain activities due to COVID-19.

Overall residents' representatives reported that they were happy with the care and support for their family member in the centre. They said communication from the community was very good and that they were pleased their family member lived in the centre. However, they thought that at times they were understaffed and that resources were stretched. They were complimentary towards the measures put in place during COVID-19.

Another residents' representative reported that their family member was well supported and cared for. They reported they were happy that Camphill had become a professionally run organisation with paid employees. They stated they would like improved communication, as sometimes invitations to meetings are at short notice.

Another residents representative described their family member as happy and reported the communication from the community was good. They reported they felt listened to and described staff as "upbeat" and stated that they feel their family member has real relationships with staff. They described how creative staff had been during COVID-19 restrictions.

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.

During this inspection, residents appeared happy and content in their homes and with the support of the staff team and volunteers. Overall the findings of this inspection were that the provider was self identifying areas for improvement in the

centre and had plans to make improvements in relation to the day-to-day management and oversight and monitoring of care and support for residents in the centre. However, as these plans were in their infancy, they were yet to have an impact. Improvement was required in relation to the staffing numbers, staff training and development, residents' contracts of care, safeguarding residents' finances, maintenance and repairs in the premises, and aspects of fire containment in one of the houses in the centre. The latest six monthly review by the provider identified that improvements were required in relation to the frequency of staff meetings and appraisals and supervisions, the notification of incidents to the Chief Inspector, and the completion of audits in line with a schedule. They also identified that audits required the inclusion of time measured action plans.

Inspectors were concerned regarding the fire safety arrangements in one of the houses and requested assurances that the required works were completed during the inspection, and that written assurances were submitted to the Chief Inspector the day after the inspection. This information was submitted as requested.

Overall, residents were protected by the safeguarding policies, procedures and practices in the centre. Residents told the inspectors that they felt safe in their homes and staff who spoke with the inspectors were aware of their roles and responsibilities in relation to the prevention, detections and response to allegations or suspicions of abuse. There were a number of live safeguarding plans and evidence that the control measures were being effectively implemented.

There were clearly defined management structures in place and staff had clearly defined roles and responsibilities. However, the provider had recognised that the centre was not adequately resourced and a quality and safety lead and administrative support had been put in place in a number of weeks before this inspection. There was a suitably qualified and experienced person in charge, who was now supported by a quality and safety lead, a house co-ordinator in each of the houses, and a regional manager. The person in charge was knowledgeable in relation to residents' care and support needs and motivated to ensure they were well supported and cared for. They were also motivated to ensure they were happy, safe and taking part in activities which were meaningful to them. They were in the process of starting to implement the new systems which were being introduced in the centre as part of the provider's national improvement plan.

The regional manager met with the inspectors during the inspection and described the changes that had been introduced in this centre over the last few weeks, since the commencement of the national improvement programme. This included one community management meeting in the centre. The regional manager had recently completed a six monthly review in the centre and had identified areas for improvement in line with the findings of this inspection. They told inspectors they would be on site in the centre more regularly moving forward and that team meetings and audits would be completed identifying actions with clear timeframes for completion of these actions.

The six monthly reviews by the provider had not been completed six monthly, in line with the requirements of the regulations. In addition, an annual review had not

been completed for 2019. In line with the national improvement plan, plans were in place to ensure they were scheduled and completed in 2021.

Staff who spoke with the inspectors were motivated to ensure residents were happy, safe and engaging in jobs, courses and activities they enjoyed. Throughout the inspection, residents were observed to receive support and assistance in a kind, caring, respectful and safe manner. Each resident who spoke with the inspector, was complimentary towards the staff team. However, there were insufficient numbers of staff to meet the number and needs of residents. The provider was aware of this and a roster review was underway. It was noted in a number of team and management meetings in the centre that staff were concerned in relation to the staffing levels in the centre. The provider had recently recruited two new staff and a relief who were due to commence in the coming weeks, but despite this there remained 1.6 whole time equivalent vacancies in the centre. There were planned and actual rosters in place. However, improvement was required in relation to the maintenance of actual rosters as some reviewed did not show that staff had moved or the person in charge had worked in the area to ensure the correct staffing numbers were in place to meet residents' assessed needs. From review of a sample of rosters in the centre, it was evident that there were a number of shifts where they were operating below the identified quota of staff. In addition, on a number of occasions, the person in charge had worked in the houses to ensure safe staffing levels. Inspectors reviewed a sample of staff personnel files and found that they contained all of the documents required by Schedule 2 of the regulations.

Staff had access to some training and refreshers in line with the organisation's policies. However, a number of staff had not completed training identified by the provider as mandatory, and a number of staff were due refresher training. Formal staff supervision had commenced and plans were in place to ensure this was completed as scheduled in 2021. Staff who spoke with the inspector were aware of their roles and responsibilities and stated they were well supported by the person in charge and the local management team.

An area identified as requiring improvement by both the provider and the Chief Inspector was the development of a new service provision agreement between the organisation and the residents. The registered provider had ensured this document had been developed and detailed the services and supports to be provided including any fees to be incurred. On review of resident files however, it was seen that the new service provision contract was not in place for all residents. While all residents had been told about the new contract and discussions had been held with them in a number of instances the easy read version was the only available copy and not all of these had the fees outlined in them.

Regulation 15: Staffing

The provider was undertaking a national review of staffing requirements. However, this was not fully completed at the time of the inspection.

Staffing numbers were not in line with the centre's statement of purpose. The provider had recently recruited to fill a number of vacancies; however, 1.6 WTE vacancies remained. As a result, there was evidence that a number of shifts were not covered resulting in the areas working under the identified staffing quota. For example in November 2020, there were six shifts where the required number of staff were not on duty.

There were planned and actual rosters in place. However improvements were required to ensure they were updated when changes were made to the actual roster.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff and volunteers had access to training and refresher training in line with the organisation's policies. However a number of staff required training or refresher training. For example;

- two staff required training in managing behaviour that is challenging

- 22 staff required refresher fire safety training

- three staff required Fire Marshall refresher training

- two staff required medication management refresher training.

Formal staff supervision was occurring in the centre, it had been identified in the providers own audits that improvement was required to ensure it was being completed as per the schedule. A schedule was in place to ensure all staff had regular formal supervision and appraisals in 2021.

Judgment: Not compliant

Regulation 23: Governance and management

There were clearly defined management structures in place. In line with the national improvement plan submitted to the Chief Inspector, by the provider improvements were required in relation to the monitoring, oversight and implementation of management systems in the centre.

The centre was not resourced to ensure effective care and support for residents. The provider had recognised this and a quality and safety lead and administrative support had recently started in the centre. The provider had recently recruited a

number of staff and was in the process of completing a roster review to identify the number of staff required to meet residents' care and support needs in the centre.

The six monthly reviews by the provider were not being completed in line with the timeframe identified in the regulations and an annual review had not been completed in the centre for 2019. The latest six monthly review by the provider had recognised the need to implement their audit schedule with time measured action plans and to follow the national compliance plan in relation to frequency of house, team and community management meetings.

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 was not in place for all residents on the day of inspection and in a number of instances the document that was in place did not state the fees to be incurred.

Judgment: Not compliant

Regulation 31: Notification of incidents

The Chief Inspector was not given written notice in relation to a number of incidents occurring in the centre in line with the requirement of the regulations. In addition, another notification had not been completed in line with the timeframe identified in the regulations.

Judgment: Not compliant

Quality and safety

The provider and person in charge were striving to ensure that residents were in receipt of a good quality and safe service. Residents were being supported to make choices, set goals and engage in meaningful work and activities. They lived in a clean, warm and comfortable home and each resident who spoke with the inspectors said they liked living in the designated centre.

Both of the houses that comprise this centre were visited by inspectors (one each). They were found to be clean, spacious, well designed, homely and meeting

residents' current specific care and support needs. Where staff administrative offices had been in one of the houses these had been moved. Each resident had their own bedroom which was decorated in line with their wishes and preferences and inspectors noted very distinct colours and styles that residents were proud of. Residents had plenty of storage for their personal items and displayed their pictures. There were private spaces available for residents to meet their visitors if they so wished. There were areas in need of maintenance and repair such as painting and repair following a leak which had caused part of a bathroom ceiling on a lower level to collapse. The flooring in the main bathrooms were affected by the hard water quality and as such appeared worn and in need of replacement. The provider had completed a number of works since the last inspection including the installation of footpaths and external lighting. They also had plans to upgrade a number of bathrooms, develop a sensory room and source a modular office to move the staff offices.

There were systems in place for the assessment, management and ongoing review of risk in the centre. There was a risk register and general and residents' individual risk assessments were developed and reviewed as required. There was evidence of review of incidents and adverse events and of learning following these reviews. Residents' risk assessments were also reviewed and updated following these reviews. Trending and learning following these reviews was shared at management meetings and plans were in place to ensure it was shared at team meetings in the future. The provider had recently reviewed and updated the risk management policy for the organisation. However, this updated policy did not contain the measures and actions to control certain risks in the centre, in line with the requirement of the regulations.

The provider and person in charge had outlined to the Chief inspector of social services in advance of the inspection that they had failed to effectively safeguard residents' finances. The person in charge had noted that a number of residents had been overpaying fees over a period of a number of years. The provider and person in charge had in line with the regulations established a formal investigation into these safeguarding concerns. This had reached its conclusion at the time of the inspection however the final outcome was not yet available in it's completed form. The provider and person in charge spoke about the findings to the inspectors, the provider acknowledged the overpayment and steps were made to prevent it from reoccurring in addition to potentially expanding the scope of review over a longer time period. Residents had not yet been reimbursed at the time of inspection however inspectors were told this was to occur.

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. Residents' personal finances were stored securely and checks and balances were being completed regularly. The inspectors viewed a sample of residents daily finances and found that records accurately reflected sums of money held by residents. The inspectors noted that all residents had money management assessments completed. However, in some instances the outcome of the assessments were not reflected in the level of support in place. In one instance a resident who had been assessed as having only a basic knowledge of money and

limited numeracy skills was noted in another document as having a solid understanding of money and in their finance support plan as being able to independently manage spending up to a specific amount. In addition for some residents while statements from a financial institution were available they had not been reviewed or reconciled fully as staff were guided by the finance support plans and not the assessment outcomes. This discrepancy between the assessed level of the residents and the levels of support had led to poor systems of oversight beyond the everyday spending for some residents. Where family members were supporting some residents to manage their finances the provider was in 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.

Apart from residents' finances as outlined above, the provider and person in charge had systems to keep residents in the centre safe. There were procedures in place and safeguarding plans were developed as necessary in conjunction with the designated officer. Staff were found to be knowledgeable in relation to keeping residents safe and reporting allegations of abuse. The inspectors reviewed a number of residents' intimate care plans and found they were detailed and guiding staff practice in supporting residents. Inspectors also reviewed the current safeguarding plans and noted that the control measures in place had been effective. Safeguarding plans were reviewed and amended as required.

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 and there was hand sanitiser and precautions available for all when opening the gate to enter the site. Each house and the office space also had a single point of entry and there were clear directions to follow prior to entering and on leaving each building. 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. 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. A number of the residents who spoke to the inspectors also indicated they knew about the virus and what they needed to do and were observed keeping distance and using the hand gel as required.

The registered provider had ensured that there was a fire safety management system in place. There were, however, improvements required to aspects of the containment of fire in one house. The laundry room opened into the main hallway of the house and the door was seen not to close correctly thus ensuring that a fire could not successfully be contained. The inspectors requested that this was repaired on the day of inspection and the person in charge ensured this was completed with written assurances also sent to inspectors the following day. In addition, two bedroom doors were seen to have significant gaps between the frame and door also not providing protection in the event of a fire. The provider had these reviewed on the day of inspection and work is required to ensure the doors contain fire as

required.

Regulation 12: Personal possessions

Improvements were required in the management of residents' finances. The inspectors reviewed a sample of financial records for residents and found that there continued to be discrepancies in the methods and consistency of oversight. In addition there were discrepancies in the assessed levels of residents and the levels of support in place.

Judgment: Not compliant

Regulation 17: Premises

Overall, the inspectors found that there was adequate private and communal space for residents and that the houses were comfortable and that the physical environment was clean. However, there were a number of areas in need of maintenance and repair as outlined in the body of the report.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider's risk management policy did not contain all of the information required by the regulations. It did not contain the measures and actions to control a number of specified risks outlined in the regulations.

There were systems in place for the assessment, management and ongoing review of risk. There was a risk register in place and general and individual risk assessments were developed and reviewed as required.

There were systems to respond to emergencies and for the review and trending of incidents and adverse events. Plans were in place to ensure learning garnered from these reviews was shared at team meetings in the future.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider and person in charge had taken a number of steps to ensure that residents were protected against a possible outbreak of COVID-19. There was regular cleaning of the premises and the inspectors observed this being implemented over the course of the visit. Sufficient PPE was available at all times and there were additional stocks available for use should there be a confirmed or suspected case identified. Staff had access to hand washing facilities and hand sanitising gels and staff were observed washing hands on entry and exit to each building at all times. Mechanisms were in place to monitor staff and residents for any signs of infection.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements to detect and extinguish fires in the centre. In one of the houses improvement was required to ensure fire would be effectively contained.

Judgment: Not compliant

Regulation 8: Protection

There were procedures to keep residents safe in this centre, the management of resident finances has been addressed as above. Staff who spoke with the inspector were knowledgeable in relation to recognising and reporting suspicions or allegations of abuse. From reviewing safeguarding plans it was evident that the control measures in place had been effective in ensuring residents remained safe.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Camphill Community Grangebeg OSV-0003621

Inspection ID: MON-0030690

Date of inspection: 14/12/2020

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Action
Completion of recruitment of approved posts
Rosters reviewed at the time of inspection did not reflect the commencement of 2 WTE Social Care Workers who took up post on the 10/12/20. 1 WTE Social Care Assistant was also in the recruitment process at the time of inspection and is near final completion.1 full permanent relief post is also at the end of the recruitment process. This recruitment process will be completed by the 31st January 2021. The center also experienced an unplanned critical illness leave for a House Co -ordinator which had to be back filed on an emergency basis. This recruitment process will reflect on staffing levels on planned rosters. .

Action: Maintenance of planned and actual roster
The COVID pandemic impacts on the planned safe staffing cover in an unpredictable and unplanned way as potentially at risk staff have to remain off site until assessed safe to return by CCOI clinical team. These changes in staffing cover are dynamic and in real time, the Person In Charge will ensure that the actual roster diary reflects these changes.

Action Completion of the review of the centre's agreed WTE.
The agreed WTE for the centre is 19.1 as stated in the centre's statement of purpose. CCOI are undergoing a national financial and operational review with the HSE as their funders. As part of this review , the senior management team are undertaking a review of the WTE for the designated centre. This involves a review with a comprehensive reassessment of individual community members underway which will recalculate their actual hours of support based on their identified need. This will provide a revised WTE for the designated center and the centre's Statement of Purpose will be changed to reflect this change.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Action : Implementation of staffing training schedule 2021.

The three staff identified as requiring Fire Marshall refresher trainings have all completed this training . Two of them took up post in the 10/12/20 and completed this training as part of their induction on the 18/12/20. The third staff members fire marshall training was omitted from the schedule by human error.
The training has been completed and booked for all staff requiring refresher training in Fire Safety, Medication Management, Fire Marshal Training & Managing Challenging Behaviour. All the required refresher training for these staff will be completed by 31/3/21

Upcoming staff training need will be reviewed each in advance of the Community management meeting and a plan to ensure upcoming training requirement will be met in a timely manner will be agreed.

The post of Quality and safety Co ordinator was filled in Grangebeg on the 2nd November 2020 . This role has responsibility to review the training tracker on a monthly basis and ensure that staff training is booked in advance to meet refresher training needs.
As part of the organizational action plan a Learning & Development officer has been appointed and will come into post before the end of January. The Learning and Development Officer will coordinate the development and implementation of an organizational training schedule for all mandatory training and will liaise and support the Quality & Safety Coordinator to manage the communities training needs on an ongoing basis. Person in charge in line with scheduled audits throughout the year reviews the training tracker as part of the audit process. Where training needs cannot be met at a local, regional or national level the Q & S will escalate these gaps in training to the learning and development officer for review by the CCOI Senior management Team.

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 Community Members with Support Needs (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 Grangebeg Community fortnightly to progress on action from Compliance plan and will conduct walk arounds within the Community. The Regional Manager will be available during these visits to offer support and advice to the community. The Regional Manager will also observe practice within the community and link in with the Person in Charge at regular scheduled supervisions.

3. PIC will complete regular spot checks and walkarounds/audit where the PIC will select a theme and review the level of compliance required in the management of the 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 Grangebeg for 2021 in line with the national compliance plan.

7. Further recruitment has taken place in January 2021

8. A review of support needs of each CMSN's has taken place. A review of WTE will be agreed and SOP updated if any change made

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Action: Review of personal files in relation to contracts of service agreement

The Person In Charge will complete a review of all residents Contracts for Service ensuring that residents who have agreed to their new contract of service and have signed an
easi read copy will also sign the agreed formal residents contract of agreement detailing the agreed residents contribution.

Where residents have not yet signed the new CCOI contract for service Person in Charge is managing a process of engagement with individuals and their families to understand and address their concerns.

The process which the PIC is implementing, is supported and overseen by the national Management of Monies and property CMSNs Group which meets weekly. This group is developing and providing national guidance on a standard engagement process to support PICs and CMSN & their families in resolving these matters.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Action

In relation to the responsibility of the person in charge in submitting all required quarterly returns and notifications within the required timelines, human error omitted submitting these returns. 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	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Action : Implementation of the revised Money management assessment tool and completion of actions identified for each community member

The Person In Charge will undertake the oversight of the implementation of the revised money management assessment tool. Each community members individual financial support plan will be revised and updated to reflect the outcomes of these assessments

PIC will review all revised money management plans to ensure they provide adequate oversight and governance of the management of each CMSN's personal finances within the community.

This plan will be agreed with each community member.

All staff will be trained in the implementation of these support plans as part of their induction

The community will be brought into an implementation plan for the roll out of the revised organizational CMSN finance policy in the month of February. 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 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Action : Completion of plan for refit of 10 bathrooms

Person In Charge will review existing estimates secured by Estate manager for refit of all 10 bathrooms within the designated centre.

The Person In Charge and the Estate Manager will consult with the Head of properties and prepare a costed and prioritized plan for the required works.

Where identified routine repairs required will be escalated to the national Repairs & Maintenance system for immediate prioritisation and scheduling of these of works.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The organizational Risk Management policy has been reviewed and updated to include all the required control measures. These changes have been shared with all management teams for cascade through staff team meetings to all staff.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Action: Monitoring of specific control measures for fire containment

Repair to laundry door hinge completed on the day of inspection.
Daily checks of laundry hinges ongoing.

In candescent fire strip on residents two way opening bedroom door has been replaced and monitoring of its maintenance is being undertaken by the Community Safety Officer, House Co-ordinator,under the supervision of the Quality and Safety Co-ordinator on a weekly basis.

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	26/03/2021
Regulation 12(4)(b)	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 in the name of the resident to which the money belongs.	Not Compliant	Orange	31/01/2021
Regulation 12(4)(c)	The registered provider shall	Not Compliant	Orange	31/01/2021

	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 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	30/04/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/01/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a	Not Compliant	Orange	31/03/2021

	continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2021
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.	Substantially Compliant	Yellow	31/12/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	29/01/2021
Regulation 23(1)(d)	The registered provider shall ensure that there	Not Compliant	Orange	31/03/2021

	is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			
Regulation 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.	Not Compliant	Orange	30/11/2021
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	31/01/2021

Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: the unexpected absence of any resident.	Substantially Compliant	Yellow	13/01/2021
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	13/01/2021
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Substantially Compliant	Yellow	13/01/2021
Regulation	The registered	Substantially	Yellow	13/01/2021

26(1)(c)(iv)	provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Compliant		
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	18/12/2020
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	18/12/2020
Regulation 31(3)(d)	The person in 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 injury	Not Compliant	Orange	31/01/2021

	to a resident not required to be notified under paragraph (1)(d).			