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:	Unannounced
Date of inspection:	25 March 2021
Centre ID:	OSV-0003621
Fieldwork ID:	MON-0031809

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:	12

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 25 March 2021	10:00hrs to 16:00hrs	Marie Byrne	Lead
Thursday 25 March 2021	10:00hrs to 16:00hrs	Conor Brady	Support

What residents told us and what inspectors observed

From meeting and speaking with residents and staff, and observing practice, the inspectors found residents appeared happy and to be enjoying a good standard of care and support. Residents told inspectors they felt safe, that they were well cared for and very happy in their homes. Improvements had been made in line with the actions outlined in the provider's compliance plan from the last inspection and the National Improvement Plan (due to ongoing levels of non-compliance across the providers services). While there were still a number of areas found to be not compliant with regulations in this centre, progress was being made based on the findings of this inspection.

Improvements observed in this centre were resulting in better outcomes for residents living in the centre. There had been changes in the governance structures and a number of new systems were in the process of being implemented, and there was now a clear focus on quality and improvement in line with the provider's national assurance plan. Areas for improvement in relation to resources and financial safeguarding required further review and improvement and will be discussed in greater detail later in this report.

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 met a number of residents and staff members including two house co-ordinators, a regional manager and a quality and safety leader. To decrease footfall in the centre each of the inspectors visited one location in the centre, and they reviewed documentation in a separate office location. These measures were to promote best practice in prevention against infection.

There were twelve residents living in the designated centre on the day of the inspection, and the inspectors had the opportunity to meet with 10 residents over the course of the inspection. Feedback from residents was mostly positive in relation to their care and support and a number of residents told inspectors that they were very happy living in the centre. However, a number of residents did tell the inspectors that more staff were needed in the centre and that there was a lot of changes with different staff and managers.

The designated centre comprises of two large two storey houses situated in a rural 40 acre organic farm and estate. Each of the houses consist of two communal sitting rooms, two kitchens, laundry rooms, a number of bathrooms, and each resident has their own bedroom. Bedrooms were found to be clean and well ventilated. On the grounds there is a large hall, bakery, arts and crafts room and pottery.

Residents were being supported engage in a range of activities of their choice in the designated centre including day services, farming, horticulture, landscaping, and grounds and estate management. They were also accessing creative pursuits such

as weavery, arts, pottery, baking, cooking and food preservation, music, dance and drama, should they so wish. A number of residents were also accessing virtual literacy and educational programmes on the day of inspection.

Residents have access to a number of vehicles to support them to access their local community. From reviewing residents' goals and speaking with residents, they had been taking part in activities in line with their wishes and goals prior to the current level of restrictions relating to the COVID-19 pandemic such as, going to the cinema, theatres, concerts, musicals, going out for meals and drinks, attending the local gym and visiting their family and friends. Due to the closure of some of these amenities, residents were being supported to have different experiences and explore other activities in their home or on the farm in order to keep busy.

Events were regularly organised to celebrate special occasions and events. There was an upcoming outdoor barbecue planned to celebrate two residents' milestone birthdays. Residents were being supported to contact their relatives and friends regularly and a number of residents were being supported to visit their families in line with risk assessments and public health advice. A number of residents were choosing to wait until they had were fully vaccinated to visit their relatives and friends.

Residents hold weekly house meetings where they hold discussions in relation to things like their menu, upcoming events,and the maintenance and upkeep of their home. The organisation has a national advocacy group where residents who chose to participate in it are supported to do so. Residents are supported by a keyworker to develop and review their goals and residents' rights, complaints and advocacy are discussed regularly. Residents and their representatives' views are being captured as part of the six monthly visits and annual review by the provider.

Residents were observed coming and going around the farm and grounds during the day and to enjoy spending time in their preferred outdoor spaces. One resident who was out and about on the grounds spoke with one of the inspectors about their love of farming. They talked about how much they enjoyed working on the farm and talked about lambing season. They talked about different staff in the designated centre and were complimentary towards how they were supporting them and discussed the new staff who were due to start working in the designated centre. They told the inspector that staff were keeping their lunch warm for them and described what was for lunch. They said it wasn’t their favourite meal and then went on to describe what their favourite type of food was. The inspector met one resident who had been in day services and then they had just gotten their 1st COVID-19 vaccination. They smiled and showed the staff member and the inspector the spot where they had gotten their vaccine and then went to the kitchen to tell another staff member.

While positive findings were made for residents in a number of areas as outlined above, equally further important improvements were also required. The governance and management in place on the day of inspection represented a recently reviewed structure and some were not the personnel who usually managed the centre. The main areas of concern observed were in relation to governance, safeguarding,

staffing/resourcing and staff supervision/oversight. In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

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.

This risk based inspection was also completed to verify the actions outlined by the provider in their plan following the last inspection in the centre in December 2020. Overall the findings of this inspection were that improvements were noted across an number of regulations reviewed. However, the centre remained under-resourced and this was found to be impacting on the provider's ability to bring about some of the planned improvements in the designated centre. The inspectors also found that changes made by the provider were in their infancy and yet to fully impact the day-to-day management of the centre. This was a key consideration in terms of the providers ability to implement and embed organisational changes and assurances that have been provided to the Chief Inspector.

Staff reported to a house co-ordinator in each of the house who were both met as part of this inspection. House co-ordinators reported to the quality and safety lead and person in charge, and the person in charge reported to a regional manager who was identified as a person participating in management of the centre (PPIM). This inspection was facilitated by the quality and safety co-ordinator (who was fulfilling the role of person in charge on the day of inspection) and the PPIM both of whom had recently commenced in the centre. They had both worked in other roles in other Camphill Communities of Ireland prior to taking up their new posts. The quality and safety lead had commenced in the centre at the end of 2020 and they had been responsible for the day-to-day management of the centre for a number of weeks prior to the inspection due to the person in charge being on leave. They were found to be knowledgeable in relation to residents' needs and preferences and motivated to ensure they were happy and safe in their home.

Overall, residents appeared to be happy and content, and a number of residents told

the inspectors that they were happy and felt safe while living in the centre. Staff who spoke with the inspectors stated that they were well supported by the local management team and that they could raise concerns about the quality and safety of care and support with the house coordinators, person in charge or quality and safety lead should the need arise.

Improvements were evident since the last inspection in relation to residents' access to and control over their finances, staff training, admissions and contracts of care, the notification of incidents to the Chief Inspector, and fire precautions in the centre. Although improvements were noted in relation to these areas, further improvements were still required in relation to staffing resources in the centre, staff training and development, residents' contracts of care, risk management and safeguarding residents' finances.

In line with the findings of previous inspections, the provider was aware that there were insufficient numbers of staff to meet the number and needs of residents in the centre. They had completed a dependency needs assessments and a roster review and submitted them to the Health Service Executive (HSE) for their review for additional resources.

Although improvements were found in relation to staff accessing training and refresher training, there remained a number of staff who required training/refresher training and these will be detailed later in this report. The provider had implemented a new system to record training, identify training gaps and for ensuring staff were booked onto the required courses. A learning and development officer had just commenced in post. Staff supervision was not being consistently completed due to resource issues in the centre. No supervisions had taken place for most of the staff reviewed. There was a supervision schedule in place to ensure staff were in receipt of regular formal supervision moving forward in 2021.

The provider had clearly defined admissions procedures and these were outlined in the organisation's policy and the centre's statement of purpose. Residents admissions were found to be competed in line with these policies and procedures. The provider had prepared a new contract of care for each resident and most were agreed. An accessible version was available that clearly laid out the changes between the two contracts. Residents were provided with opportunities to provide informed feedback on the changes. However, one residents' contract of care was not fully completed at the time of the inspection.

Regulation 15: Staffing

There were six staff vacancies at the time of the inspection. The provider was aware of this and had recruited to fill these positions. New staff were due to commence in the designated centre in April 2021. A roster review had been completed which included residents' dependency needs assessments and this had been submitted to the HSE for their review, with a view to securing additional staffing resources for the

designated centre.

The provider was attempting to ensure continuity of care and support for residents through the use of regular relief staff and the use of occasional regular agency staff. However, there was also an over-reliance on staff completing additional hours to ensure that all the required shifts were filled.

There were planned and actual roster in place. However, from reviewing a sample of rosters improvements were required. For example, the second name of some regular staff, and some short term co-workers were not included on a number of rosters reviewed. In addition, there were no names included for the agency staff who worked two shifts and staff's unplanned leave was not included on a number of rosters reviewed.

A sample of staff files were reviewed and they were found to contain the majority of information required under schedule 2 of the Regulations. However, the full employment history together with a satisfactory history of any gaps in employment, were not in place in two staff files reviewed.

Judgment: Not compliant

Regulation 16: Training and staff development

For the most part staff had access to and were completing training and refresher training in line with residents' assessed needs. However, a number of staff required the following training/refreshers:

- 1 staff required manual handling training

- 7 staff required online PPE training

- 6 staff required epilepsy rescue medication training

The inspectors viewed evidence that staff were booked onto some of these trainings.

Due to a lack of staffing resources in the centre, staff supervision was not been completed as planned in line with the organisation's policy and their National Improvement plan.

Judgment: Not compliant

Regulation 23: Governance and management

The management structure had made progress based on this inspection with competent persons found to be managing the service on the day of inspection. The Regional Manager outlined the centres commitment to ongoing change and improvement in line with the providers National Improvement Plan.

Improvements were noted in relation to the management systems in place since the last inspection. There had been an increased presence of senior management in the centre and they were in the process of exploring methods to implement enhanced supports to ensure this centre was implementing all of the various elements of the provider's National Improvement Plan.

The centre remained under-resourced at the time of the inspection and this was found to be impacting on the providers ability to fully implement the planned improvements in the centre. In addition, commitment to ongoing managerial oversight, supervision and monitoring of staff performance and development and safeguarding (SIMT) assurance all required further improvements.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Residents were found to be protected by the admissions policies, procedures and practices in the centre. The procedures in place considered the wishes, needs and safety of the residents and the safety of other residents living there.

Where possible, residents and their representatives had the opportunity to visit the centre prior to admission.

For the most part residents had a contract of care which included the support, care and welfare of the resident, details of the services provided and the fees to be charged. However, one resident did not have an updated contract of care in place at the time of the inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the designated centre was maintained. The Chief Inspector was given notice in writing within the specified timeframes of all of the required incidents in line with the requirements of this Regulation.

Judgment: Compliant

Quality and safety

The provider and local management team were striving to ensure that residents were in receipt of a good quality and safe service. Residents were being supported to make choices in their daily lives and to stay busy engaging in meaningful activities during the pandemic. From what the inspectors observed when visiting the two houses in the designated centre residents lived in a clean, warm and comfortable homes. A number of residents told the inspectors they were happy, felt safe and were well supported by the staff team. The provider was in the process of completing a serious incident review in relation to financial safeguarding at the time of the inspection. From evidence reviewed this required further investigation.

Inspectors reviewed the systems for residents to access and retain control of their personal property and possessions. The registered provider had submitted an improvement plan addressing this area due to non-compliance's identified during a number of inspections. The inspectors viewed a sample of residents' daily finances and found that record balances accurately reflected receipts and outgoings. Clear documentation was maintained by staff of expenditure made by residents, and this was checked and signed off by management team regularly. Residents now had money management assessments completed and support plans were developed as required. They were clearly identifying the levels of support, if any, residents required to manage their finances.

There were policies and supporting procedures for ensuring that residents were protected from all forms of abuse. Residents were being supported by staff to develop their knowledge, self-awareness and understanding of safeguarding through keyworking sessions and residents' meetings. Concerns had been previously highlighted in the centre in relation to financial safeguarding. A serious incident review/investigation was initiated by the provider in relation to these concerns. These were specifically related to financial practices and the overcharging/fees paid by a number of residents in the centre over a period of time. This investigation report was viewed on the inspection and highlighted that five residents were affected, and had overpaid their fees between 2016 and 2020. The provider had made arrangements to reimburse the five residents who had overpaid their fees for the full amounts listed in their report. Inspectors found that this had been completed and residents were reimbursed in full.

However incidental investigation findings indicate a further more thorough review is required for the period 2006 to 2015. Such a review had been previously requested by the Chief Inspector at national level from this provider in April 2020.

The summary conclusion from the providers own investigation report dated 11 December 2020 found that 'there were failures at every level to ensure the residents at Grangebeg were contributing the correct amount throughout the period 2016 - 2020' and 'the additional absence of sufficient oversight systems at regional level and insufficient governance at national level missed the opportunity to identify the

poor practice'. Inspectors were informed that the provider has made a decision to widen the timeframe to review residents contributions and amended the terms of reference of their investigation to reflect that a review would be completed for 2006 to 2015. This review was due to commence in the centre on 29 March 2021.

Two residents had recently transitioned to the centre from another Camphill Communities of Ireland community. It was evident that they had been supported to transition to the centre in a planned and safe manner. Comprehensive transition plans were in place which detailed the steps involved in supporting residents, including a video tour of the centre prior to their transition. At the beginning of their transition residents were supported by regular staff who they were familiar with from the centre they had transitioned from. Residents were also being supported to attend their regular day services placement and to stay in touch with residents and staff from the other centre. The inspectors met with both residents during the inspection and they reported they were happy in the centre and had settled in well.

Overall, residents were protected by the risk management policies and procedures in the centre. The organisation's risk management policy had been reviewed and updated since the last inspection and now contained the required information. Some improvements were required regarding the updating of all risk documentation to reflect risk management practices. For example, the centre’s risk register did not fully reflect the centres risks as some risks needed to be removed and the risks relating to the lack of resources in the centre needed to be added. A risk was identified on the day of the inspection relating to the maintenance and cleaning of laundry equipment. Procedures for the cleaning of lint from dryers were not being fully implemented in one of the houses.

There were effective fire management systems in place and the provider had brought about the required improvement in relation to fire containment in the centre since the last inspection. Suitable fire equipment was available and regularly serviced and there were adequate means of escape which were kept unobstructed, and emergency lighting was in place as required. The evacuation plan was available and on display and each resident had a personal emergency evacuation plan in place. These plans were sufficiently detailed to guide staff in relation to the support residents required to safely evacuate the centre. Fire drills were occurring regularly and adequate arrangements were in place to ensure each resident could be supported to safely evacuate the centre in the event of an emergency. Staff who spoke with the inspector were knowledgeable in relation to the supports each resident required to safely evacuate the centre.

Suitable and safe procedures were in place relating to medicines management and staff were knowledgeable on the needs of residents relating to prescribed medicines. Regular audits were being completed and staff had access to training to support residents. For example, a number of staff had also completed training in relating to the administration of epilepsy rescue medications, and more staff training in their area was planned for April 2021.

Both premises visited during the inspection were found to be clean. There were cleaning schedules in place, to ensure that each area of the house was regularly

cleaned, including regular touch point cleaning. The provider had developed or updated existing policies, procedures, and guidelines to guide staff practice in relation to infection prevention and control during the pandemic. There were adequate supplies of personal protective equipment (PPE), and systems in place for stock control. There were sufficient handwashing facilities and supplies of hand sanitiser available and systems were in place to ensure residents, staff and visitors were checking their temperatures regularly.

There was evidence to demonstrate that residents were supported to exercise their rights and to be included in decision making processes about their care and support. They were also being supported to exercise choice and control over their daily lives. Residents' rights, advocacy, complaints and the impact of restrictions relating to COVID-19 were being regularly discussed at keyworker and residents' meetings.

Regulation 12: Personal possessions

Overall residents were being supported to access and control their own belongings and their personal possessions were being respected and protected. Residents had easy access to their personal monies and where necessary they were being supported manage their financial affairs in accordance with their wishes.

Each resident now had a financial assessment and support plan in place. Records and receipts of their personal possessions and spending were maintained and they were being regularly audited.

The matter in the centre regarding financial safeguarding is referenced under Regulation 8.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were being supported to access facilities for occupation and recreation. They were being supported to participate in activities and to access education, training and employment in accordance with their wishes and interests.

A number of residents told the inspectors about what they liked to do and how important certain activities were to them. They talked about how they were being supported to keep busy during the pandemic.

Residents were being supported to develop and maintain personal relationships and links with the wider community in line with their wishes. They were being supported to stay in contact with their family and friends during the pandemic.

Where residents had recently transitioned between services, continuity of their day service and preferred activities were being maintained.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Where residents had recently transferred from another designated centres, planned supports were put in place. Residents and their representatives were consulted with and kept informed throughout the process.

Relevant and appropriate information about residents was transferred between the designated centres.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risk. There was a risk register and general and individual risk assessments were developed and regularly review. However, the risk register required review to ensure if was reflective of the current risks in the centre.

There were systems in place to review incidents and adverse events and to share learning amongst the staff team following these reviews. These reviews were also leading to the update of residents' risk assessments where required.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had policies and procedures in place in relation to infection prevention and control and they had developed and adapted existing policies and procedures to guide staff practice during the COVID-19 pandemic.

For the most part staff had completed hand hygiene, infection control and PPE training. A number of staff required online PPE training, but in the interim they had completed area specific training.

Both premises were found to be clean during the inspection and there were cleaning

schedules in place to ensure all areas of the houses were regularly cleaned.

There were supplies of PPE available and systems in place to ensure there were adequate stocks available at all times.

Judgment: Compliant

Regulation 28: Fire precautions

There was suitable fire equipment provided and it was serviced as required. There were adequate means of escape and emergency lighting in place. Improvements relating to the maintenance and cleaning of laundry equipment is captured under regulation 26.

The procedure for the safe evacuation of the centre in the event of an emergency was available and on display. Residents had personal emergency evacuation plans which clearly guided staff in relation to any support they may require to safely evacuate the centre.

Regular fire drills were occurring and detailed any learning garnered following the drills. This learning was then translating to the review and update of residents' personal emergency evacuation plans.

Staff had completed fire safety awareness training and those who spoke with the inspectors were knowledgeable in relation to how to support residents to safely evacuate the centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Residents were protected by the policies, procedures and practices relating to medicines management in the centre. There were appropriate systems in place in relation to the ordering, receipt, prescribing, storing, disposal and administration of medicines.

There were appropriate procedures for the handling and disposal of unused and out of date medicines. Staff had completed training to support them to carry out their roles and responsibilities in relation to medicines management. Regular medication management audits were being completed.

Judgment: Compliant

Regulation 8: Protection

There were systems in place in the centre to ensure that residents were protected and safe from abuse. These systems were described in the registered provider’s safeguarding policy and procedure.

A review of notifications submitted to the Chief Inspector and records held in the centre showed that any concerns that had arisen since the last inspection had been reported and investigated as required, and appropriate actions had been taken.

Staff were knowledgeable on current safeguarding plans which had been developed in response to safeguarding concerns in the centre. Staff members spoken with had completed safeguarding training and were able to demonstrate knowledge of their roles and responsibilities in relation to suspicions or allegations of abuse.

However, regarding the provider's investigation into the financial management/safeguarding of residents' monies, this remained incomplete. Inspectors were not assured based on the evidence reviewed that residents' finances had been appropriately protected at all times and the incidental findings of the providers investigation highlight further investigation and possible further recompense is required to residents.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' meetings were occurring regularly and it was evident that residents were being kept up to date in relation to any developments in the designated centre and were being involved in the day-to-day running of the centre. They were being supported and encouraged to exercise their independence and choice in their daily lives.

There was information available for residents in relation to the availability of advocacy services should they wish to access them and their was also information available in relation to their rights. Residents were being supported and encouraged to maintain their privacy and dignity and throughout the inspection staff were observed to treat residents with dignity and respect.

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	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Camphill Community Grangebeg OSV-0003621

Inspection ID: MON-0031809

Date of inspection: 25/03/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Recruitment • 3 WTE posts have been recruited since the inspection: • 1 WTE commenced in post 21/4/21. • 2 WTE commenced in post 4/5/21. • 1.5 WTE in schedule 2 recruitment process planned to be completed by 31/5/21. • In conjunction with the regional manager a review of staff rostering tool was undertaken in March 2021 and a new 4 week rolling roster introduced and implemented in April 2021. Ongoing review of its maintenance and resourcing in place on a weekly basis by the PIC with two House Co-ordinator with a planned and actual roster in place. • The WTE as outlined in the current Statement of Purpose is based on a dependancy needs assessment completed in 2019. A comprehensive review of the assessed needs of all residents in Grangebeg has been completed. This review has informed the staffing and skill mix required to meet the assessed needs of the residents. Furthermore, a funding verification exercise was also completed with the centre and the HSE in July 2020. CCoI have not yet received a commitment of additiional resources from the HSE.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • 1 staff required manual handling training: The staff member had completed training on	

the 15/12/20
• 7 staff required online PPE training; 4 staff members completed training on 25/3/21, 2 staff members completed training on 26/4/21,1 staff completed training on 29/4/21
• Refresher buccalam training completed
• Quality and Safety Co-ordinator reviewing training tracker on a weekly basis with oversight by PIC. Staff training reviewed at monthly supervision with Q and S . Staff training reviewed at during Monthly Regional Community Management Meeting
• Quality and Safety Co-ordinator liaises with the National Learning and Development Officer as per National Assurance Plan in terms of the co-ordination of a CCOI training schedule for all mandatory training.
• Staff supervision schedule in place ensuring that staff receive supervision in line with CCOI staff support and supervision policy. A targeted supervision schedule is in implementation led out by PIC in consultation with the House Co-ordinators to ensure that all staff receive supervision in line with CCOI policy by the 31st May 2021
• Schedule 2 audit completed 27th April. All outstanding documentation to be in place by 21/4/21

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Standardised local governance and management systems are in place since December 2020. These entail Monthly Community Management group meetings attended by regional management team (Regional Manager, Clinical Service Officer, Regional Safeguarding Lead). The Standardised Operational Procedure for this meeting was revised in April 2021 and Version 2 was implemented as per revision on the 6th of May 2021. Monthly local community management group meetings are also in place, as are fortnightly House team meetings and weekly Community Members meetings.

• Grangebeg local task group as commissioned by CEO and led by Regional Manager was set up on the 16th of March 2021. Its Purpose is to: -
1. Ensure the implementation of all actions leading out from the National Compliance Plan
2. To manage and complete a review of CMWSNS care and support requirements.
3. To introduce and implement CCOI standardized file and record systems.
4. Strengthen and reinforce Grangebeg team’s capacity to utilize the revised governance and management process and documentation.

• Membership of the task group is the Regional Manager, PIC, Quality and Safety Co-Ordinator and two House co-coordinators. The group are working through an 8-week process of implementation meeting on a weekly basis to review progress and troubleshoot merging issues. These actions are cascaded to the staff teams through their team meetings led by their HC and supported by the Quality and Safety Co-ordinator and

Person in Charge. This 8 week process is now in week 6.

• Person In Charge and Quality and Safety Co-ordinator attend weekly Learning and Develop group meetings as commissioned by National Quality and Safety Lead as per National Compliance Plan. Induction and training is provided to the local Management team in relation to the revised governance/management and clinical support systems. Identifying a clear pathway for local implementation.

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

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Outstanding contract of service was signed by Community member on the 13/4/21. All 12 community members contracts of service are signed

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Community Risk Register was reviewed by National Health and Safety Co-ordinator on the 20/4/21. Community Risk Register continues to be reviewed at Community Management Meetings on a monthly basis.
• Review of environmental risk register included the Laundry driers . Removal of lint to be included in the PIC and Quality and Safety Co-ordinator's weekly walkaround audit 10/5/21

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
SIMT commissioned by National Safeguarding lead is reviewing documentation and practice pre-2016. This documentation was reviewed by an external company as commissioned by SIMT on the 4/5/21 and some outstanding documentation is due to be

reviewed and its report and recommendation to be concluded by 30th June 2021

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 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	30/06/2021
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	30/04/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	30/06/2021

	as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2021
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	30/06/2021
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.	Substantially Compliant	Yellow	30/04/2021
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	13/04/2021

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.	Substantially Compliant	Yellow	31/05/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/06/2021