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 of Ireland Greenacres
Name of provider:	Camphill Communities of Ireland
Address of centre:	Dublin 14
Type of inspection:	Short Notice Announced
Date of inspection:	01 December 2020
Centre ID:	OSV-0003623
Fieldwork ID:	MON-0031010

About the designated centre

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

Greenacres is a residential home for three adults with an intellectual disability who require low to medium supports. The centre is located in a suburb in South Co. Dublin and is close to a variety of public transport links. There are shopping centres, pubs and local shops within close proximity of the centre. Residents have the opportunity to attend day services or avail of training, employment or volunteer work in their local community. Staffing support is provided by social care workers and volunteer care assistants and is available for residents 24 hours a day, seven days a week. The property has seven bedrooms, a kitchen and dining room, and a sitting room. The property also has a large garden with a landscaped sensory and seating area, a detached out-office and a storage shed. Each resident has an ensuite in their bedroom.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 1 December 2020	10:00hrs to 16:30hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic and as such the inspector adhered to national best practice and guidance with respect to infection prevention and control. The inspector reviewed documentation in an garden room external to the centre and visited the house intermittently over the course of the inspection. In total the inspector met with all residents who lived in this house over the course of the day. There were three residents who were all happy to engage with the inspector over the course of the day.

The residents spoken with, reported that they were happy with the service provided and spoke fondly of the staff team. They said they got on well with the staff team and liked living in the house. However, one resident while stating they liked the house did remark it was not always easy to live there as they 'bumped heads' with peers and would prefer to live alone. They also commented that the house could be noisy in particular if others were shouting or banging items and they did not like this. This issue was known to the person in charge and staff team and the resident commented positively on the support they were receiving to build their independence with a view to moving to a more independent living environment.

Residents had been supported to have meaningful days during the COVID-19 pandemic and one resident explained that they were having fish pie for dinner and that the staff would support them in going to the shop to buy the ingredients after planning in advance for what was required. Later in the day the inspector observed the resident and a staff member in the kitchen preparing the meal together. While leaving the house to venture outside was not always easy for residents they were positively supported with well defined and meaningful goals such as walking to the local shop for a favourite magazine. These personal and achievable targets were seen by the inspector to support the residents in engaging positively on a regular basis with their local community. One resident on returning from a walk told the inspector that the traffic 'was atrocious' and they may be better to wait before leaving the centre and that they liked observing facts like that.

The external room in the garden that the inspector used on the day had been laid out for residents to play music and to engage in crafts or hobbies. A resident explained to the inspector that they had played in bands over a number of years and demonstrated different cymbal and drum types as well as explaining their amp set up. Another resident explained that they liked a particular shop which had been closed due to the COVID-19 pandemic but was due to reopen the day of inspection and they were they said very excited to be able to go to the shop again.

The inspector observed a resident leaving for day service in the morning and they explained they can walk or go in the vehicle, they were reminded by staff to protect themselves from COVID-19 and the resident told the inspector they wore a visor and used hand gel before they left the house. Over the day the inspector observed staff interactions with residents and they were relaxed, comfortable and enjoying the

company of staff members. Staff were seen to be warm in their interactions with residents and attentive to their needs.

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 programme 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 while predominately completed to inform a decision regarding renewing the registration of the centre also formed part of this national monitoring programme of Camphill Communities of Ireland.

Overall the inspector found that the person in charge and the staff team had ensured that the individuals living in this designated centre received a good quality service. This inspection found evidence, across the regulations reviewed, of a service that supported and promoted the health, personal and social needs of the residents.

The centre had a clearly defined management structure in place, consisting of an experienced person in charge who was supported in the house by a full time and experienced house co-ordinator. The person in charge worked on a full-time basis in the organisation and was supported in their role by a regional manager who had been involved in this centre for the last year. There were good reporting systems evident between the person in charge and the staff team.

The registered provider had ensured that an unannounced visit to the centre to review the quality and safety of care provided to residents had been carried out in October 2020, with an external review of the service by another provider also having taken place. However these reviews had not been taking place prior to this on a six monthly basis as required by the regulations. The registered provider now had a proposed schedule in place to ensure these occurred as required going forward. It

was seen that an initial action plan was in place following the last unannounced visit. In addition there was an annual review of the quality and safety of care available in the centre with evidence of liaison with residents and their representatives. The person in charge had a system of audits in place that occurred on a monthly basis and issues highlighted in these were observed to have been acted on. In addition weekly reviews were in place which were completed by the house co-ordinator and reviewed by the person in charge.

There was one staffing vacancy at the time of the inspection. The person in charge outlined that the centre had had a stable staff team until the departure of a staff member and as such a contingency or relief panel had not been required until now. The provider was in the process of recruiting to fill this position and was attempting to minimise the impact of these vacancies on residents by staff completing additional hours and by using regular agency staff. The person in charge and regional manager had submitted a business case to the registered provider to try and build contingency staffing measures into the staffing arrangements. There were two volunteers who lived in the centre in line with the ethos of the provider and on review of the roster it was seen that they did not provide unsupervised overnight support and there had been a recent provider audit of their responsibilities and the hours they provided support to residents. Further review of staff rosters showed that not all staff who were on duty were clearly identified. A review of staff files by the inspector showed that not all documents as required by Schedule 2 were in place for the staff who were covering the vacancy.

Staff were provided with relevant training to assist them in supporting residents. The person in charge had taken some steps in relation to staff training to prepare for a possible outbreak of COVID-19. The training records viewed indicated that all staff members and volunteers had completed training in infection prevention and control, hand hygiene and in donning and doffing of personal protective equipment (PPE). All staff were in receipt of support and supervision provided by the house co-ordinator and person in charge in line with the providers policy.

The residents were encouraged and supported to raise complaints if they choose to do so, and arrangements were in place for any complaints to be resolved locally where possible. Relatives or residents representatives were aware of how they could make complaints if required. On the day of inspection no complaints had been received since the previous inspection and a complaints log was maintained however, there were some compliments recorded.

The registered provider had ensured the development of a new service provision agreement between the organisation and the resident. This document detailed the services and supports to be provided including any fees to be incurred. This had been an area previously identified as requiring improvement by both the provider and the chief inspector of social services. On review of resident files it was seen that a new service provision contract was in place for all residents, in addition to an easy read version. One of the residents had completed an overview of the main distinctions between the previous service provision agreement and this one and this overview document had been read by the inspector in other centres run by the provider. The resident outlined what they had done to produce the document

and the inspector explained that they had found it helpful to read.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted all documentation as required under the regulations to renew the registration of this centre. A number of these documents required review however and were to be resubmitted following the inspection, including the statement of purpose and the residents guide.

Judgment: Compliant

Regulation 15: Staffing

The numbers and skill mix of staff were suitable to meet the assessed needs of residents. There was a current vacancy that the provider was in the process of recruiting for and this was currently covered by the use of two consistent staff from an agency. Review of the rosters showed that identification of all staff on duty was required and some staff files did not contain all documents as required in Schedule 2.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to training and refreshers in line with residents' needs. Staff were in receipt of formal supervision and support from the person in charge.

Judgment: Compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure in place consisting of an experienced person in charge and house coordinator. They were also supported by a

regional manager.

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

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

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

Judgment: Compliant

Regulation 31: Notification of incidents

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

This report had been submitted for quarter three in 2020 but not previously.

Judgment: Not compliant

Regulation 34: Complaints procedure

Procedures were in place in relation to complaints. A complaints officer was in place and the residents and their relatives or representatives were aware of how they could make a compliant if required. A complaints log was maintained.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents lived in a warm, comfortable and relaxed home. The staff team were supporting residents to engage in meaningful activities and to live a life of their choosing. While there were ongoing compatibility issues between residents that had resulted in a number of safeguarding issues these had been adequately addressed. The residents themselves outlined to the inspector what had been put in place to support them and the decisions made to support them in increasing their independence skills in a positive manner.

The inspector found that the person in charge and house co-ordinator were proactively protecting the residents in the centre. They had appropriate procedures in place and staff had access to training to support them to carry out their roles and responsibilities in relation to safeguarding. The person in charge was actively engaged with the residents regarding practices in place to support them. A review of safeguarding plans informed the inspector that for one resident there were specific protocols in place to ensure their safety and protection when they were engaging with individuals outside the centre. The person in charge had also ensured that if referrals to external agencies had been required these had occurred in a timely manner.

Systems were in place to manage and mitigate risk in the centre. Where required, each resident had number of individual risk assessments on file so as to promote their overall safety and well-being. For example, where a resident may be at risk of injury while using garden tools a number of control measures were in place (such as demonstration of safe use of the equipment and supervision) to mitigate this risk. There was evidence that following incidents or adverse events new risk assessments were completed, for example following a recent rodent sighting new controls were put in place. However it was noted that for one risk assessment completed in April 2020 where it had been noted that a resident was at risk of choking an onward referral to speech and language therapy was not completed until this was noted in the external provider visit. On the day of the inspection the referral had been completed.

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. The premises were observed to be clean, there was sufficient access to hand sanitising gels and hand-washing facilities and all staff had adequate access to a range of personal protective equipment (PPE) as required. All staff had received training in this area as already stated.The infection control contingency procedures had been updated to include a guidance document to prevent/ manage an outbreak of COVID-19. Staff and visitor temperatures were also taken prior to entering the house. One resident explained to the inspector how they kept themselves safe and were observed wearing their visor leaving the house. Another resident had the role of health and safety representative for the residents in the house with responsibility for COVID-19 and they explained their personal duties

to the inspector.

Staff spoken with were knowledgeable regarding processes in place for the management of residents' finances. All residents had up to date money management assessments and each had an individualised financial management procedure in place. There were systems in place for the recording of daily expenditure for those that required this level of support and regular oversight of statements for those that required less support. The inspector viewed all residents' finances and found that records accurately reflected sums of money residents had. Residents' personal finances were stored securely. Where support was required to budget, a system to manage this had been put in place by the person in charge following consultation with the resident and their family member. All residents had an up to date record of their personal assets and belongings and this had been completed in the month preceding the inspection by the person in charge and house co-ordinator.

Overall, the residents in this centre were supported by the policies, procedures and practices relating to medicines management. From review of documentation and discussion with the person in charge it was apparent that this was an area where significant improvements had been made recently. There were incidents involving staff such as, untrained staff administering medicines, that had led to formal investigations and review of and improvements to practices. In addition while there had been a kardex or record of prescriptions in place clear medicine administration records had not been kept as required. Following the external providers audit identifying this as a concern the person in charge had liaised with the providers clinical management team and a new system was now in place. There were on the day of inspection suitable practices in place relating to ordering, receipt, storage and disposal of medicines. Residents were being supported following a risk assessment and assessment of capacity to take responsibility for either aspects of or total responsibility for the self administration of their medicines. Medication audits were completed regularly in the centre. Actions were developed with a clear timeframe for their completion. These actions were bringing about improvements in relation to medicines management in the centre.

Regulation 12: Personal possessions

All residents had full access to their money at all times and had access or oversight of their accounts. Staff and management supporting residents had sufficient oversight of the residents' spending or finances and provided support as appropriate. Up to date records were kept of residents assets and personal possessions.

Judgment: Compliant

Regulation 26: Risk management procedures

The safety of residents was promoted through appropriate risk assessment and the implementation of the centres' risk management and emergency planning policies and procedures. There was evidence of incident review in the centre and learning from adverse incidents.

However, following an external provider review it was noted that one aspect required improvement. It was observed that after a recent risk assessment one resident should have been referred to speech and language therapy for an assessment. This had been completed however on the day of inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The person in charge and the provider had taken steps in relation to infection control in preparation for a possible outbreak of COVID-19.

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

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were appropriate policies, procedures and practices relating to the ordering, receipt, prescribing, storage and disposal of medicines. Audits were completed regularly in the centre. The person in charge and house co-ordinator had linked with the providers clinical team and recent changes had been made to improve the practice of recording administration of medicines.

Judgment: Compliant

Regulation 8: Protection

There were procedures to keep residents safe. Staff had completed training in relation to safeguarding residents and the prevention, detection and response to abuse. Staff who spoke with the inspector were knowledgeable in relation to recognising and reporting suspicions or allegations of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted with and participating in the day-to-day management of the centre and making choices in relation to how they wished to spend their time. Residents' meetings were occurring regularly in the centre and they were kept up to date in relation to the pandemic. Residents held positions of responsibility within the house for specific activities. There was information available and on display in relation to the availability of advocacy services, and one resident told an inspector about how they were being supported to transition to another house in line with their wishes and preferences.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Camphill Community of Ireland Greenacres OSV-0003623

Inspection ID: MON-0031010

Date of inspection: 01/12/2020

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 15 (4) - The planned and actual staff rota has been amended (04/12/2021) to show names and position of staff on duty during the day and night and this shall be maintained ongoing. 15(5) - Review completed 21/12/2020 of all agency persons employed HR files in line with Schedule 2 (HR). Documents that were not contained have been identified and information has been requested from the Agency. Where there is agency staff employed, on duty a system has been put in place to ensure that the full name and position (e.g., SCA or SCW) are identified on the roster. All rosters will have this data going forward.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider had identified this weakness and prior to inspection put in place a system for conducting six month unannounced inspections and annual review of quality and safety. 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 Greenacres 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 Greenacres for 2021 in line with the national compliance plan.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
PIC identified the procedure as a restrictive practice and reported same in quarter three in 2020 and will continue to submit quarterly. A review by the clinical team confirmed this as a restrictive practice.
Consent to implementation restrictive practice form has been completed and consent obtained from resident with review date in 6 months' time.
This restrictive practice is also on CCOI restraints tracker.

Regulation 26: Risk management procedures	Substantially Compliant

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

management procedures:
Referral for speech and language assessment sent by GP to St. Colmcilles Hospital in Loughlinstown on 10/11/2020. Follow up by PIC with the person GP in December confirmed that the referral was made and the CMSN is are awaiting an appointment for the assessment. The CMSNs is support at mealtimes by trained staff who are aware of the risk assessment and ongoing monitoring for deterioration is in place. The effectiveness of the support pan for this CMSNs at mealtimes is reviewed as part of the Community Management Meetings.

The organizational risk management policy has been revised and updated and an operational risk register for the community has been developed and was implemented in late November 2020.

As part of the implementation of the Risk Management Procedures on an ongoing basis all open risks for the community will be reviewed as a part of the monthly Community Management Meeting and actions required in the management of these risk will be tracked and monitored to ensure speed resolution and where this is not possible to ensure the escalation of the matter to the Regional Manager and appropriate support function as required for further action.

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(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	04/12/2020
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	18/01/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as	Substantially Compliant	Yellow	31/01/2021

	determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 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	31/01/2020
Regulation 31(3)(a)	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 occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/01/2021