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 Kyle
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	07 and 08 July 2021
Centre ID:	OSV-0003625
Fieldwork ID:	MON-0033548

About the designated centre

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

Camphill Community Kyle provides long-term residential services for a maximum of 17 residents, over the age of 18, of both genders with intellectual disabilities, physical disabilities and autism. The centre is located in a rural setting and comprises six units of two-storey detached houses and standalone apartments with each accommodating between one and five residents. All residents have their own bedrooms and other facilities throughout the centre include kitchens, dining rooms, sitting rooms, utility rooms, bathrooms and staff offices. In line with the provider's model of care, residents are supported by a mix of paid staff (including social care staff and care assistants) and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 7 July 2021	10:00hrs to 19:30hrs	Sinead Whitely	Lead
Thursday 8 July 2021	09:30hrs to 17:00hrs	Sinead Whitely	Lead
Wednesday 7 July 2021	10:00hrs to 19:30hrs	Tanya Brady	Lead
Thursday 8 July 2021	09:30hrs to 17:00hrs	Tanya Brady	Lead
Wednesday 7 July 2021	10:00hrs to 19:30hrs	Conor Brady	Support
Thursday 8 July 2021	09:30hrs to 17:00hrs	Conor Brady	Support

What residents told us and what inspectors observed

This inspection was completed over two days and involved three inspectorate staff, ensuring all six locations that make up this designated centre could be inspected. While restrictions were easing in relation to the COVID-19 pandemic, the inspectors at all times adhered to public health guidance and national best practice relating to infection prevention and control. A full review of documentation was completed in a building separate to the residents' homes over both days. In advance of the inspection, inspectors had completed a review of all information submitted to the chief inspector both requested and unsolicited since the last inspection of the centre. This included information of concern in relation to a serious incident where a resident had left their home without staff knowledge and was found by a member of the public a number of hours later.

This designated centre comprises of six residential units in a rural setting which is registered for a maximum of 17 residents. Following the most recent inspection in March 2021 where inspectors found a very poor standard of safe and quality care delivered to residents, this inspection found that improvements were evident. However, inspectors also found that the registered provider had to further improve in a number of areas to demonstrate compliance with regulations. For example, the areas of governance and management, safeguarding, risk management, fire safety and premises. Camphill Communities of Ireland also had to demonstrate an improved ability to resource, manage and sustain improvements in this centre on an ongoing and consistent basis.

There were 17 residents living in the centre and inspectors met all residents over the two days of this inspection. The inspectors spent time with staff members and the management team aligned to the centre. In addition the inspectors had requested that the provider inform all resident families and/or family representatives that this inspection was taking place. Inspectors spoke with six families at their request by telephone over the course of the inspection.

Inspectors received both positive and negative responses regarding this centre from families spoken with. For example, some families were very complimentary about front line staff but heavily criticised some members of Camphill Communities of Ireland executive and board in terms of decision making, organisational management and communication with residents families. Many also communicated positive feedback regarding care practices, staff in the centre, and the support given to their family members during the COVID-19 pandemic.

Some staff who spoke with the inspectors stated that they continued to be concerned regarding the number of agency staff on the roster and how this impacted on consistent care delivery to the residents. They also identified difficulties in supporting some residents in houses where there was incompatibility between residents.

Inspectors observed some residents supported by staff leaving the centre on outings such as going for a picnic. Other residents were less engaged and one resident was observed on one day to be on their own walking around the site looking into windows for the entire time inspectors were on site. This resident was observed spending large periods of time unsupervised without any formal or structured programme or activities in place. There were no systems in place for staff, to direct them on when to alert if the resident did not return home nor a process if the resident was gone from the house for longer than specific time frames. This was in contrast to control measures laid out in some risk assessments for this individual resident reviewed by inspectors.

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

Capacity and capability

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

Following the March 2021 inspection, the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of the centre. As is their right under the Health Act 2007, as amended, Camphill Communities of Ireland submitted formal representation to the Chief Inspector setting out why the centre's registration should not be cancelled and outlining their proposed actions to come into compliance with the regulations.

This inspection was carried out to review progress against the actions set by the provider to come into compliance with the regulations in their submitted formal representation and to review actions set by the provider in their compliance plan from the March 2021 inspection. There had been another complete change in the management team of the centre since the last inspection in March 2021and in particular this was the third person in charge since that time.

Overall this inspection found that the registered provider had demonstrated a number of improvements in the provision of safe and quality care required for residents in this centre. A new person in charge had been appointed since the previous inspection. This person was found to demonstrate the capacity and

capability to effectively manage and oversee the designated centre. New auditing and checking systems had been implemented and inspectors noted marked improvements in areas including medication management, training, and the management of residents finances. A significant amount of work had been completed by management and staff, since the previous inspection, to implement these checking systems and drive improvements in the centre.

However, further improvements in a number of areas continued to be required, in particular in relation to fire precautions and resident safeguarding.

Regulation 15: Staffing

The registered provider had completed a review of the staffing levels required in this centre and had increased the allocation of staffing with a further increase to be implemented. While there continued to be a high use of agency staff to cover gaps in the roster the provider and person in charge had attempted to ensure these staff were allocated to specific houses where possible to try and improve consistency of staffing for residents.

The inspectors found that residents assessed needs were being used to inform staffing levels in place to support them. Rosters were reviewed and found to be clear and accurately reflected the staff on duty on the days of the inspection. An analysis tool had been developed by the management team to determine the required staffing levels in the centre to safely and effectively support the residents.

Inspectors completed a review of staff personnel files and found that all Schedule 2 documents were in place as required including Garda vetting, photo identification and evidence of qualifications.

Judgment: Compliant

Regulation 16: Training and staff development

Overall, improvements were noted in the area of staff training and development since the centres previous inspection. Training was completed by staff in areas including safeguarding, first aid, manual handling, medication management, infection control, epilepsy management, dysphagia, and childrens first. A checking system was in place to review staff training needs and schedule refresher training when required. There were twelve members of staff outstanding on refresher manual handling training on the day of inspection.

All staff had regular one to one formal supervisions every eight weeks with line managers. The person in charge had implemented a checking systems to track these and ensure that this was scheduled and carried out in line with the service

policy. Clear records of supervisions and audits of supervisions were maintained and available to the inspectors.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had changed the management team in place in this centre since the last inspection in March where new personnel had also been in place. The person in charge was found to be implementing systems as established by the provider and had been working to ensure that they were familiar with all residents and had visited all units that comprise this centre. The provider had not ensured they had achieved all qualifications as required by the regulations however, on the day of inspection these had been initiated and were due for completion within a number of weeks.

The governance and management team in this centre has completed a significant body of work to change levels of compliance within this centre. However, the majority of changes required remained resource dependant.

The person in charge had established meetings with all house co-ordinators and team leaders on a regular basis which had improved communication within the existing staff team. In addition other regular meetings were taking place within the community management team and with the registered provider. Minutes from these were reviewed and were seen to follow consistent agenda items ensuring that the areas of concern as identified were reviewed on an ongoing basis.

A six monthly review of the quality of care and support provided in the centre had been completed and there was evidence that the actions identified in this were being followed up although completion of a number of these remain resource dependant such as, alterations to the physical environment. Additional audits had taken place and progress against actions identified in these was also monitored and reviewed. However, inspectors noted that recent retrospective reviews by the Health Service Executive had identified significant incidents not identified by the providers own reviews.

Judgment: Not compliant

Regulation 31: Notification of incidents

One restrictive practice was noted on the day of inspection that had not been notified on the quarterly reports to the Chief inspector, as required by Regulation 31.

Judgment: Substantially compliant

Quality and safety

Inspectors reviewed a number of key areas to determine the quality and safety of care provided. This included a review of care practices, risk management documentation, safeguarding records, residents personal plans, audits, staffing levels, cleaning records, fire safety documentation, financial records and medication systems. Overall, improvements were noted in the quality and safety of care and support provided since the centres most previous inspection. However, some improvements were still required to promote safer practices and higher levels of compliance with the regulations

Residents' support needs were assessed on an ongoing basis and there were measures in place to ensure that residents' needs were identified and met. This was well reflected in the residents personal plans and supporting documentation. Overall it was found that the centre had the resources to meet residents' needs. Some areas of the premises required maintenance and improvements as detailed under regulation 17.

Fire safety required improvements in areas including containment and fire evacuation routes and exits. An immediate action was issued in relation to this on the day of inspection. A second immediate action was issued on the day of inspection in relation to risk management. Furthermore, inspectors found further improvements were required to ensure that residents were safeguarded at all times and that medicines were managed safely at all times.

Regulation 12: Personal possessions

The inspectors found significant improvements in the management of residents personal possessions. Asset registers had been developed for all residents with clear guidance for staff on completing and maintaining them. Staff were able to explain these to inspectors and they were seen to be detailed.

Systems were in place for the recording and monitoring of resident finances and all residents had an updated capacity assessment in place which outlined the level of support they required. There was evidence of regular auditing and checks by the person in charge and the providers finance manager and 'on the spot' audits were also taking place. The provider and person in charge had reviewed risks in the centre and there was evidence that this was an area that had improved since the last inspection

While some residents remained without access to or control of their own funds the

provider had been working with families to ensure they had sight of bank statements which allowed for reconciliation of spending. Significant liaison with families was happening by the person in charge and the house coordinators.

Judgment: Compliant

Regulation 17: Premises

Some improvements had been made to the premises since the last inspection with some new furniture in places and areas that had been painted. There was a homely atmosphere in many of the communal areas and kitchens observed on this inspection.

However, considerable improvements are required both internally and externally to ensure that the residents have clean and comfortable homes that are laid out and designed to meet their needs. One resident was observed using a fire escape and accessing their home through a small elevated door with a steep drop evident on entering. Some resident bedrooms were observed to be very small with staff/co-worker accommodation found to be much larger. Other rooms were seen to require cleaning with them presenting with a musty smell. Some residents told inspectors that they would like to have a bath but there was no access to a bath in their home.

Judgment: Not compliant

Regulation 26: Risk management procedures

An immediate action was issued to the provider on the day of inspection under this regulation.

Inspectors noted a box placed to the side of a walkway where residents were observed passing. This box contained the remains of a swarm of bees. The inspectors requested this area be immediately cordoned off and residents protected from the risk of being stung while this was removed.

The provider and person in charge had reviewed risks in the centre and there was evidence that this was an area that had improved since the last inspection. The tracking and monitoring of risk was observed to be improved with control measures in place against identified risks. However, inspectors found that for a number of individual risks the control measures in place were not being adhered to or they required further development. This included risks regarding harm if using machinery or equipment for example, where the main control measure for individuals was adequate staffing but inspectors observed the resident unsupported in the farm area and around other sections of the site with machinery. The risks of a resident going

missing/absconding for example required further development and as stated earlier there were no protocols in place should this happen. This was of particular relevance in this centre as residents had gone missing without staff knowledge in previous incidents in this centre.

Judgment: Not compliant

Regulation 27: Protection against infection

There were a number of measures in place for protection against infection in the designated centre. Hand washing facilities and alcohol gels were located around the houses and staff were observed wearing face masks in line with national guidance for residential care facilities.

However, inspectors reviewed a sample of cleaning records and found gaps and inconsistencies with recording systems for cleaning being completed. Some areas were observed in one house as requiring deep cleaning however this area had significantly improved since the previous inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

An immediate action was issued to the provider on the day of inspection under this regulation.

Inspectors observed that the identified evacuation route for one resident was blocked with boxes on the floor and that the exit door could not be opened by either the inspector or the staff on duty and appeared to be locked. This was reviewed by the provider and the inspector observed it opening prior to leaving the centre. In addition, the floor area was cleared before inspectors left on the first day to give assurance evacuation could occur.

The provider had completed their own internal fire safety audit and had identified that a number of areas relating to the containment of fire required urgent review. A specialist company was on site to assess the integrity of fire doors over the course of the inspection. Reports given to inspectors indicated that doors in a number of houses had 'warped' and did not fit into frames thus were not effective to contain fire or doors presented with large gaps between the door and the frame. This was of concern as this centre had already experienced a fire (small external electrical fire) requiring the local fire brigade to attend since the last inspection. In addition, where a resident had transitioned from another of the providers centres due to fire containment concerns they were now residing in a house with similar

issues/concerns.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found that the policies, procedures and systems in place for the management of medication in this centre had much improved. There had been a serious incident management team review in place at the last inspection due to poor practices in this area and for one resident in particular. This was subject of a lot of work and oversight and the review had concluded and practices had been revised and updated. Medication practices were now being audited on a regular basis and this was found to have improved the quality of care in this area.

There were systems in place in relation to the prescribing and disposal of medicines. Effective systems were in place in relation to the administration of medicines and in the administration of medications with PRN (as required) protocols in place. Further minor improvements were required in ensuring that liquid medications, and topical creams or ointments were dated as required, once opened.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors reviewed the safeguarding register in the centre and met with the regional safeguarding manager in addition to the designated safeguarding officer for the centre over the two days. Inspectors also spent time in all houses and with residents and staff. Inspectors found that no residents were at immediate risk in the centre. However, a number of houses within the centre had residents living together that were incompatible and this was leading to high numbers of incidents and residents living in stressful environments.

A high number of recorded safeguarding incidents continue to be reported in this centre with no reduction in the occurrence of these. It was of concern to inspectors that a number of incidents had been identified from a review of the providers records that was completed by the Health Service Executive and these had not been identified by the provider themselves. These were incidents of a serious nature such as a resident found early in the morning unaccompanied on the site in a state of undress and staff had not realised they were missing from their home. A serious incident of a similar nature had occurred since the last inspection and the safeguarding measures in place were reviewed by inspectors with additional control measures now found to be implemented post incident.

There were two serious incident management team reviews in place in this centre which had not been concluded at the previous inspection, one of these related to misappropriation of resident funds. Both of the reviews were now concluded at the point of this inspection with the residents reimbursed on the second day of this inspection. Significant incidental findings however, remain outstanding with the provider stating they were committed to ensuring full financial redress for the additional amounts identified as owed would be reimbursed to all residents involved. These had not been completed on the days of the inspection.

Inspectors were concerned that while there was a lot of safeguarding reporting and recording (documentation) taking place amongst a cohort of staff responsible for same - timely and effective safeguarding action was not as evident. This needs to be addressed by the registered provider to ensure safeguarding concerns are responded to in a timely and effective manner.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents spoken with appeared happy and well supported. Residents meetings took place on a regular basis and social stories had been implemented for some residents regarding changes in the centre and recent HIQA inspections. Inspectors observed residents engaging in different individual activities including going out for walks and a picnic, playing music and arts and crafts. One resident told the inspector that their birthday was soon and that they would be going to the zoo. Some residents had been supported to access advocacy services. Inspectors observed some mealtimes and residents appeared to have choice in what was served and, at times, were involved in preparing and cooking meals.

Compatibility of residents continued to be an issue in the centre and impacted some residents choice and control in their daily lives. Two residents living together could not access all aspects of their home at all times due to safeguarding risks. Inspectors heard one resident in another house discussing a peer who had been shouting loudly during the night and had given them a headache. The provider needed to reassess compatibility of residents in some parts of this centre to ensure all residents rights were being promoted.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Camphill Community Kyle OSV-0003625

Inspection ID: MON-0033548

Date of inspection: 07/07/2021 and 08/07/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. All outstanding staff have now been trained in Manual Handling Training on 11/06/21. 2. A full review has been conducted on the training needs in the community with the Head of Service and PiC. 3. PiC and Admin staff review training tracker monthly to plan forward. 4. Training is a set agenda item on the Community Management Meeting. 5. Training is discussed in monthly supervisions with the House Co-ordinator's and PiC. 6. Further training has been identified to meet the needs of the community members and to promote professional development with the staff teams. First session completed on 08/09/21.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. PiC has completed relevant course to obtain management qualification on 28 July 2021 with certification in Mid-November. This will be forwarded accordingly. 2. PiC, RM, HOS and HSE have been engaging to identify and assess the resources required. 3. PiC continues to lead out the compliance plan in Kyle with the local team supported by the Regional Manager. 4. The PiC supported by the team leads are providing direct support, monitoring and	

oversight for a number of houses, continuing visual daily inspections, support and ensuring following up for improvement.
5. Regular House and Community management meetings are established, where areas of concern continue to be discussed and actions followed up on.
6. Business case has been sent to the HSE for property upgrades. A meeting to discuss this with HSE was held on 17/08/21 and the Chief Assistant Technical Services Officer & Fire Officer– Capital Estates visited on 10/09/21 where they completed a visual inspection of all rooms in the designated center.
7. PiC and Team Leads review and respond to all incidents as they occur actions are identified, reviewed and learning shared at house and community management meetings. All incidents are escalated to RM, HOS and CEO for review.
8. New ViClarity system is being implemented organizationally which will support the management and governance of the center into the future.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. A review of all restrictive practices is currently underway, and all retrospective notifications will be made by 31/10/21.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

1. Business case has been submitted to the HSE for property upgrades, meeting to discuss this with HSE was held on 17/08/21 and the Chief Assistant Technical Services Officer & Fire Officer of the HSE Capital Estates visited on 10/09/21 to assess the works for funding.
2. A property review was conducted with HOS, PiC and Team Lead on 08/09/21 to review the accommodation for all Community Members. This was reviewed in the meeting with the Chief Assistant Technical Services Officer & Fire Officer from HSE Capital Estates on 10/09/21. It includes structural work to address the size of the rooms.
3. A work plan has been developed and a schedule of works agreed. The works will be carried out and completed in order of priority.
4. Bathroom upgrades are included in the proposed works which will address the

community members having access to the bath in their homes.
5. Community Members have been supported to complete vision boards of what they would like their rooms to look like and painting works have commenced throughout the community.
6. Deep cleaning and de cluttering has happened throughout the community. House Co-Ordinator's are now completing a daily walk around to monitor this at handover each morning. PiC with the support of team leads also carry out regular walk around to ensure that this is kept up.
7. A suitability assessment of accommodations was completed by HOS and PiC. A plan was identified to provide more suitable accommodation for community members and alternative spaces for volunteers and office spaces.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. Pest control were called at 8am on the morning of the inspection. Learning was shared at the next Community management meeting. Materials are retained on site in the event of an incident that requires an area being cordoned off.
2. A further review of the individual Risk Assessments has happened and was concluded 19/07/21. Additional control measures were put in place where required. This will continue to be a standing agenda item on the community management meetings as well as House management meetings. They are reviewed accordingly as per timeline in risk management policy or as required following an incident.
3. All missing from care / absconding protocols have been reviewed, appropriate guidance has been provided to all staff members and discussed at house management meetings.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. Standardised cleaning records have been implemented across the community. A deep clean and declutter has taken place. House Coordinators are completing daily walk arounds and PiC and Team Leads are carrying out spot checks in the community throughout the week.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

1. Social Story is being shared with Community member regularly in relation to fire safety in their home.
2. The escape routes are checked as part of the daily means of escape checks.
3. The Thumb lock of the external fire exit door was repaired on the day of the inspection.
4. Capital funding has been agreed with the HSE to replace the fire doors. A fire door survey has been completed on 07/07/21 and we await confirmation from the company for lead time of installation of doors.
5. The HSE Chief Assistant Technical Services Officer & Fire Officer from the HSE Capital Estates office completed a visual inspection of all rooms in designated center on 10/09/21 to assess works for funding.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. Introduction of a weekly Medication Audit, this is completed by PiC supported by Team Leads and House Co-Ordinator's.
2. The details on the Kardex identified by the inspector on the day have been corrected to state that the medication is a liquid in form.
3. Kardex's are reviewed every 6 months with the GP or more frequent if required.
4. All topical creams, ointments and sun cream have a label. Checks of this are included in the weekly medication audit.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. There is a robust system of reviewing incidents. As they occur actions are identified, reviewed and learning shared at house and community management meetings. All incidents are escalated to RM, HOS and CEO for review.
2. An applied and action based approach to safeguarding is being rolled out in the community, applied safeguarding training was completed with staff on 8th June 2021, staff are supported to understand and operate to residents safeguarding plans. The supports for each residents inclusive of safeguarding are reviewed monthly by the staff and PIC.
3. There has been a reduction in Safeguarding incidents in the community reducing from 42 cases to 19 currently. The PiC supported by the Team Leads and house coordinators are communicating with staff teams, and it is discussed regularly at team meetings to ensure that the staff are aware of the actions relating to the safeguarding plans.
4. Full commitment from the organization is given to ensure full financial redress for all additional amounts that have been identified is made.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. CCOI have introduced a Compatibility Assessment. This tool will be used to review the compatibility of Residents where repeated peer to peer issues is arising
2. A property review was conducted with HOS, PiC and Team Lead on 08/09/21 to review the accommodation for all Community Members. The plan was presented on 10/09/21 with the HSE, who assessed all buildings. This includes assessing the suitability of the buildings to meet the assessed needs of the residents.
3. The Chief Assistant Technical Services Officer & Fire Officer from the HSE Capital Estates visited Kyle on 10/09/21. From this meeting CCOI will take action from the works identified, there will be plans to get works completed with additional needs for surveying with bringing consultants in for further review.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/12/2021
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.	Not Compliant	Orange	30/04/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/12/2021
Regulation 17(7)	The registered provider shall	Substantially Compliant		30/04/2022

	make provision for the matters set out in Schedule 6.			
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	30/11/2021
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	31/07/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/07/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare	Substantially Compliant	Yellow	31/07/2021

	associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/04/2022
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/04/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/04/2022
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration	Substantially Compliant	Yellow	31/07/2021

	of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
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.	Substantially Compliant	Yellow	31/10/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	07/07/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/12/2021