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:	25 March 2021
Centre ID:	OSV-0003625
Fieldwork ID:	MON-0031663

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
Thursday 25 March 2021	10:30hrs to 18:00hrs	Tanya Brady	Lead
Thursday 25 March 2021	10:30hrs to 18:00hrs	Sinead Whitely	Support

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic, inspectors adhered to all public health guidance with respect to infection prevention and control. All units of this centre were included in the inspection with inspectors visiting three houses each, donning and doffing required levels of personal protective equipment at entry and exit of each house. Inspectors met with residents, staff and management, observed practice and reviewed documentation. The review of documentation took place in a separate building (clean zone) to ensure compliance with public health guidance and HIQA's enhanced inspection methodology. Inspectors met and spoke with residents in their homes, as they moved around the site or when residents called to the office building over the course of the inspection. Inspectors met with 16 residents over the course of the day.

This designated centre consists of six residential units located in a rural setting, registered to provide care and support to a maximum of 17 residents. There were 17 residents living in the centre on the day of inspection. The site also contains a working farm, multiple buildings used for activities and day services in addition to a centre shop. The site is very large with extensive surrounding fields and farmlands and a number of houses surround a vegetable garden.

At the previous inspection of this designated centre in July 2020 living arrangements for two residents were identified as being highly restrictive. In particular, concern was expressed with respect to the arrangements for keeping one of these residents safe within their home at times when their peer presented with behaviours that challenge. Actions had been identified by the provider following the last inspection however, on review it was clear that no progress against these actions had been made. For both residents this meant they did not have full access to their home and one of these residents had no access to the kitchen, dining or main living room in their home. The inspectors noted that this situation had not changed and that no plans were in place to improve the quality of life for these residents. An inspector met with both of the residents and the staff in the house on the day of inspection. The staff have systems in place to alert one another at night if residents are up and moving with staff moving to prevent access where possible from one area of the house to another.

A resident in another house outlined to an inspector that they felt anxious and annoyed as another resident in the designated centre had entered their home without permission on a number of occasions and had caused damage to their personal belongings. The resident outlined that they had been advised to keep their door locked but they were worried they would forget to do this and so were now checking it regularly. This was of concern to inspectors that the provider was not in a position to protect the resident in their own home other than to advise them to lock doors. Staff spoken with outlined how the reduced staff resources did not allow them to fully ensure this residents safety.

The provider had submitted information of concern to the Chief Inspector of Social Services regarding poor and unsafe practices in administration of medication to a resident in this designated centre. The impact of this on the resident was being reviewed by a serious incident management team and assurances had been provided by the provider to the Chief Inspector prior to this inspection. As such, the area of medicines and pharmaceutical services was reviewed in detail on this inspection. Errors and inconsistencies were still identified by inspectors on the day of inspection both with respect to the resident who was central to the providers concerning findings and other residents. It was identified that further improvements were needed to ensure that medications were always administered safely by staff in this centre.

This inspection found that the provider not only continued to be significantly non-compliant in areas previously identified by inspectors in the July 2020 inspection but that levels of non-compliance had overall increased, which was of particular concern for the residents living there. While progress with some actions such as, review and closure of historic safeguarding cases had been made, there were a number of significant findings on this inspection regarding the level of restrictive practices in place, safeguarding of residents, staffing levels and medication management. These findings were inconsistent with assurances given to the Chief Inspector by this provider following the previous inspection and the national provider assurance plan.

Staff on duty presented as familiar with residents, their likes and dislikes and their daily routines. Some staff however told inspectors that they were providing cover in houses they were less familiar with as there was a shortfall of staff in the centre and more experienced staff were used in positions of lone working. Residents were seen supported by staff in taking walks to the farm and other residents had been supported to attend appointments or go for a drive. Staff were observed supporting residents at coffee time and chatting with residents in the kitchen of their home. Another resident had been supported to clean the floor in their kitchen and to complete household tasks they enjoyed. One resident was sitting outside with a collection of stones that were very important to them and they explained to the inspector how they sorted and arranged these. This resident requested that the inspector not touch the stones or other items that were important and asked staff to repeat this direction. The inspector reassured them that their personal items would not be touched and the resident was reassured by this. Inspectors had been greeted by a resident who was moving around the centre on arrival and who later requested to show the inspector around their home.

Inspectors noted outstanding maintenance works around the centres houses throughout the day. Fresh painting was required in several areas and general maintenance such as, filling of holes in walls where fixtures had been moved, curtains in one residents bedroom were falling from rails as hooks were broken, a residents' go kart had been left in a flower bed outside one house and was now rusted and covered in weeds. Furniture was identified around the centre that required upholstering or replacement.

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

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 on previous inspections, 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 unannounced inspection formed part of this national monitoring programme of Camphill Communities of Ireland.

This inspection found that the provider continued to be not compliant in areas identified on the previous inspection with the exception of infection prevention and control. However, non-compliance was also found in additional regulations reviewed on this inspection. There were a number of significant findings on this inspection regarding the safeguarding of residents and the use of restrictive practices in addition to the management of medication which are outlined in the next section of this report. These findings were inconsistent with assurances given to the Chief Inspector prior to the inspection by this provider. This centre had not moved towards regulatory compliance in the areas inspected despite the providers national improvement plan being in place.

There was a new person in charge in the centre on the day of the inspection who was the second person in charge to be appointed since the previous inspection eight months earlier. The provider had not submitted the required information to the Chief Inspector in relation to the appointment of this individual within the time frame required by regulation. This meant that it was not possible for inspectors to make a judgment as to whether this individual who was holding this position had the required qualifications, Garda vetting, skills and experience to fulfil the role of person in charge.

The centres staff team consisted of social care workers and support workers. Some voluntary co-workers also continued to provide care and support to residents at times. The centre did not have the full whole time equivalent of staff as identified on their statement of purpose on the day of inspection. Management communicated that recruitment for these staff members was in process. Staff shortages meant that at times the centre was reliant on relief agency staff members to cover and fill shifts very regularly. Staff supervisions were being completed regularly, however it was

identified that seven staff members were overdue their annual performance management meeting with a line manager as per the service policy.

The inspectors reviewed a sample of staff files and found that all Schedule 2 documents were in place as required. Staff training records were also reviewed. Training was provided in areas including fire safety, manual handling, medication management, safeguarding, infection control, behaviour management and diabetes management. It was identified that some training was overdue. For example a staff member required refresher fire safety training, another two staff members required refresher training in manual handling, two staff needed initial medication management training and one staff member was due refresher safeguarding training.

Registration Regulation 5: Application for registration or renewal of registration

An appropriate application for the renewal of registration of this centre had not been received as required within the time frames as set out in the regulations.

Judgment: Not compliant

Registration Regulation 7: Changes to information supplied for registration purposes

The registered provider had notified the chief inspector that there had been a change of person in charge for this centre however no accompanying documentation had been submitted within the time frame as required in the regulations.

Judgment: Not compliant

Regulation 15: Staffing

The registered provider was aware that there were insufficient numbers of staff to meet residents assessed needs and that they were heavily reliant on agency/relief staff to cover shifts. The provider and person in charge were endeavouring to cover gaps in the roster with the use of consistent agency staff in addition to relief staff. However, as evident on the day of inspection this was proving to be difficult with review of rosters highlighting that four agencies were in use across the centre, with multiple shifts covered by agency staff over the course of a week in a number of the houses. The agency staff were referred to on the roster only by first name and

agency name which did not allow for assurance regarding skill mix of staff or for identification of staff on duty.

Inspectors reviewed staff personnel files and found that they had improved since the previous inspection and contained all of the information, as required in Schedule 2 of the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

Following a review of staff training records, it was identified that a number of staff were due either initial or refresher mandatory training in areas including fire safety, manual handling, safeguarding and medication management. Staff supervisions were being completed regularly, however it was identified that seven staff members were overdue their annual performance management meeting with a line manager as per the service policy.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that management systems were in place in the designated centre to ensure that the service provided was safe and appropriate to the residents needs. There was a new governance structure in place since the last inspection and it was not clear for residents that they were aware of the current changes in personnel with inspectors noting photographs and details of the previous person in charge still displayed in residents homes.

While audits were being completed they were not occurring as required, for example, a provider audit of resident finance forms noted that the end of month audits had not taken place for the preceding three months for a number of residents. An annual review of the quality and safety of the care and support in the centre had taken place for 2020 and this had a number of actions identified as an outcome. Six monthly unannounced visits had not been completed as required with one having been completed in November 2020 and the previous one in February 2020, however these did identify actions. It was unclear however, whether these actions were completed or how progress was recorded against these.

There were two provider led reviews of serious incidents in this centre and they had not been completed within the provider timeframe as required. The inspectors had reviewed the draft report for one of these reviews at the last inspection and note that identified dates and actions at that stage had not been adhered to. In addition,

actions identified at the centres most previous inspection had not been fully addressed by the provider within the time frames as identified by them.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Contracts for the provision of services to residents were reviewed and the samples viewed by the inspectors were all signed and the providers new contract was in place. The samples viewed outlined services to be provided to residents and the fees that would be charged.

The providers annual report had however, self identified that two residents remained without a contract in place and the provider was liaising with resident representatives with respect to this. In addition for one resident who did not have access to their own finances the amount of fees indicated on their contract did not match the amount recorded as being paid and the provider continued to liaise with resident representatives regarding this.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents of resident injuries, namely skin ulcers, had not been notified to the Chief inspector as required by regulation 31.

Judgment: Not compliant

Quality and safety

The person in charge and the staff team in the centre were trying to ensure that most residents were in receipt of a safe service. Inspectors noted that residents met with on the day of inspection appeared as well cared for. While inspectors did meet a resident who was out on the site while still in night clothes the staff were able to outline attempts made to ensure the resident was warm and that their dignity had been considered.

This centre consists of six residential units located in a rural setting. Overall the premises were clean but required maintenance with furnishings also requiring replacement or updating in a number of houses. Inspectors highlighted two areas of

concern with respect to fire precautions, as outlined below, to the person in charge and provider on the day of inspection with assurances given that these would be amended immediately.

The registered provider failed to protect residents from all forms of abuse. Not all residents in this centre were found to be safe and protected on the day of inspection. While some residents spoken with, told the inspectors they felt safe and well supported in their homes, others reported feeling anxious and concerned. On the previous inspection a number of identified concerns regarding financial safeguarding specifically related to financial practices and the irregular management of residents money in this centre were discussed. A serious incident review/investigation was in progress by the provider in relation to these concerns in addition to a review regarding alleged failings of care to a resident. The provider assured the Chief Inspector that the investigation would conclude and on completion, residents would be reimbursed and the investigation report would be submitted in full to the Chief Inspector and the Health Service Executive Safeguarding Team. This investigation report was sought on this inspection and remains not completed. Inspectors were informed that the investigation was at draft stage and awaiting Board approval. The number of residents affected was highlighted as 10 who are reportedly owed a significant amount of money in redress.

Inspectors found that improvements were required to ensure that residents medication was always administered safely. Senior management had completed a review of residents medication management following serious and concerning staff medication administration practices identified in previous months. A serious incident review/investigation was in progress by the provider in relation to these concerns. However, errors and inconsistencies were still identified by inspectors on the day of inspection which did not find appropriate and safe systems in place.

Regulation 12: Personal possessions

The registered provider and person in charge had not ensured that residents had full access to, and retained control of, their own finances. Some residents continue to receive small weekly amounts as a 'float' and while changes had been implemented since the previous inspection with advocates now involved in supporting a number of residents, the provider still did not have oversight and a means to complete audits. Staff in houses were able to explain the new system for the recording and checking of finances however, when inspectors reviewed the recorded and actual balances there were still discrepancies albeit for small amounts for some residents. For example, for one resident an error had occurred in the daily tallies this was not corrected for four nights indicating that the actual amount had not been checked and cross referenced.

Judgment: Not compliant

Regulation 17: Premises

All houses comprising this designated centre required some maintenance both internally and externally. The houses were warm and comfortable and all were clean with residents bedrooms decorated in a manner personal to them. However, painting was required and general maintenance such as, filling of holes in walls where fixtures had been moved, curtains in one residents bedroom were falling from rails as hooks were broken, a residents' go kart had been left in a flower bed outside one house and was now rusted and covered in weeds. Furniture was identified around the centre that required upholstering or replacement. One resident expressed that they would like a bath, but did not have access to one and instead used a shower.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Measures were in place for infection prevention and control. The centre had implemented additional measures in light of the COVID-19 pandemic. Systems had been amended or implemented since the previous inspection with respect to monitoring of temperatures in fridges and freezers and there was a clear water testing programme in place in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

Inspectors highlighted two areas of concern to the person in charge and provider on the day of inspection with assurances given that these would be amended immediately. In one house flammable materials were being stored in a hot press next to heated pipes, and in another house the washing machine and tumble dryer were in the main hallway by the bottom of the stairs. This was the main circulation space in the house and there were no systems in place to ensure that the tumble dryer was checked for the presence of lint nor that these appliances were not in use when the resident was asleep. Further review of fire safety measures across the centre were therefore required.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found that improvements were required to ensure that residents medication was always administered safely. Senior management had completed a review of residents medication management following serious and concerning staff medication administration practices as identified in previous months. These practices had resulted in a serious incident management review with assurances given by the provider to the Chief Inspector. However, errors and inconsistencies were still identified by inspectors on the day of inspection both with respect to the resident who was central to the providers concerning findings and other residents. One resident had two working medication prescriptions in place with contradictory medication doses and times and it was not clear which identified the correct information. Furthermore, this residents medication prescription did not identify medication routes of administration. Following a review of a sample of other residents medication, it was found that one residents medication did not match the dose and times outlined on their prescription. It was found that residents prescriptions for medication administered as required (PRN) did not always match directions on PRN protocols in place for the same medication.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured that residents were protected from all forms of abuse and felt safe at all times in their own home.

The inspectors noted that the provider had completed a significant number of reviews of older (2018 and 2019) safeguarding plans and had ensured these had been closed or updated as required since the previous inspection.

Money management assessments had been completed for residents in the centre and updated support plans on managing their finances were in place for residents. The previous HIQA inspection had reviewed a provider serious incident review of inappropriate retrospective management of finances for a number of residents in this centre. Inspectors were informed that these cases were pending conclusion at the time of inspection as outlined by the provider. However, the investigation report was not available on the day of this inspection and had not been finalised. Ten residents are reportedly owed a significant amount of money in redress and this remains outstanding. In addition a second part of serious incident review was in relation to alleged failings of care to a resident over a period of time and a formal process involving staff had still not concluded.

Judgment: Not compliant

Regulation 9: Residents' rights

As a result of the restrictions in place in one of the houses in this centre two residents were not being granted the freedom to exercise choice and control in their daily lives. One resident had no access to the kitchen, dining or living room in their home as a result of safeguarding concerns and while this had been acknowledged by the provider at the previous inspection nothing had changed for the resident.

The right to privacy for another resident in a different house was also a concern where another resident had entered their home without permission and the resident was directed to lock their doors as a protective measure.

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	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
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	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Camphill Community Kyle OSV-0003625

Inspection ID: MON-0031663

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Registration Regulation 5: Application for registration or renewal of registration</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration:
1. CcoI recognise that a different organisational structure is required to ensure governance and oversight at community level. CCOI intend to restructure Kyle into 2 2 designated centres, with the 2 Pics' directly managing the social care workers and staff teams. These PIC's will be managed by an Area Services Manager.

2. CCoI will commence the process of submitting new registration documentation for 2 designated centres by the end of June 2021.

3. The interim structure outlined below has evidenced the requirement for the PIC to be closer to the community member and the team who support them. CCoI are proposing a new community structure to ensure the required governance and oversight is in place to ensure safe and effective services with 2 PIC's and one Services Manager.</td></tr>
<tr><td>Registration Regulation 7: Changes to information supplied for registration purposes</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes:
1. A new PIC has been appointed- all documentation has been submitted on the 30/4/21</td></tr>
</table>

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.

Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. Recruitment has been progressed for new staff to strengthen the skill mix across the community. 5 new WTE have been recruited to date and recruitment is ongoing for 6 more WTE
2. Onboarding of these new staff will commence on the 5th of May and continue over the next 4 weeks.
3. CCoI is targeting the replacement of all agency staff on the roster through the recruitment of core staff and the creation of a relief panel to support absences. Rolling recruitment will continue until consistent staffing and relief panels are in place. Advertising is in place on multiple platforms.
4. Comprehensive review of staffing requirements against the assessed needs of the Community Members has been completed by CCoI, who are actively engaging with the HSE for the resources required.
5. 2 permanent WTE staff have returned from extended leave during April immediately reducing the community's reliance on cover.
6. Preferred agency providers have been identified and where agency staff continue to be required all measures to ensure a continuous line of cover is in place with named staff familiar to the Residents working in allocated houses are in place.
7. The full names of all staff have been included on the roster.

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. A full review of the training needs of the community was undertaken on the 8th April by the HR team.
2. A training schedule has been completed to ensure all outstanding training requirements will met by 30/6/21
3. A review of the supervision and appraisal schedule was completed between 19/4/21 and the 23/4/21. All outstanding annual appraisals will be completed by 14th of May 2021

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The CCoI National Quality & Safety Lead is providing an active management oversight role in this community until the successful restructuring has been achieved in line with national task force project.
2. As an urgent action the existing management structure was reviewed, and an interim management structure was put in place from 12/4/21. The team include the interim PIC with skill and experience in achieving compliance, 2 Team Leads.
3. The 2 Team leads provide direct support, monitoring, and oversight for a number of houses, with each completing visual inspections daily, supporting the development of good practice with the frontline teams, and are working intensively to embed a standard range of CCoI processes to evidence person centred care and support, and ensure heightened governance at house level. The Team Leads ensure that each Community Member with support needs have their weekly schedule of planned supports and meaningful engagement delivered by the teams who support them through their daily checks and supports to the team.
4. The local management team at Kyle have a daily meeting to review the previous days actions, track progress, identity and action areas for improvement in line with a targeted work plan.
5. Weekly review meetings are chaired by the National Quality & Safety Lead and involve the local management team, heads of function to share progress, track actions completed for the previous week, agree a workplan for the week ahead.
6. A dynamic Improvement Plan has been created for this community to integrate the findings and actions from the unannounced inspections, annual reviews, including the outstanding actions from the 2020 reports as well other audits & reports into a single management tool.
7. Progress is tracked on this tool and will be reviewed on a monthly basis with the PIC as part of their supervision. Information will be shared with the team and actions assigned at community management meetings.
8. The annual review for the service was completed in January 21 and unannounced provider inspection was completed in March 21
9. The new PIC has been introduced to all residents in their home and a formal notice which included the PICs photograph and details has been placed in all Resident homes.
10. An audit of Residents finances electronic files was undertaken by the Residents finance officer on the 27/4/21. The required actions have been incorporated into the communities Improvement Plan. Progress against these actions will be reported on monthly by the PIC as part of their supervision
11. The PIC has commenced the outstanding retrospective monthly audits of the Residents daily financial records in the community. This audit will be completed on 1/5/21 and the required actions will be incorporated into the community Improvement

Plan 12. Both SIR reports have been finalised. (see Regulation 12 below)	
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: 1. A full audit of CMSN contracts commenced on 24/4/21, any incorrect amounts recorded will be identified and addressed by 31st May 2021. 2. National guidance by CCoI to advance unresolved engagements with families in relation to oversight of Residents finances and contracts for service is being progress to address these areas. See Regulation 12 protection	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: 1. Notification of a foot ulcer for one resident was missed in quarterly notifications for the 3rd and 4th quarter of 2020. This was a human error. Staff entering the notifications could not find a notification for skin ulcer (NF39e) in the disability section of the portal and understood that an NF39d notification was not appropriate and therefore assumed no notification. 2. Retrospective notifications on NF39d have been submitted on 30/4/21.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: 1. House Coordinators check the reconciliation of CMSN's accounts against personal finance form, daily logs and cash on hand daily and the Team Leads oversee the completion and accuracy of these checks each day. PIC completes 2 spot checks per week to assure accuracy. 2. Training has been provided for the Kyle House Co-Ordinator's in the new policy and	

SOP on 13/4/21 & 27/4/21.
3. Team Leads are overseeing a program of review and the updating of all Money Management Assessments and Plans per CMSN and Personal Asset Registers using the templates for the new CMSN finance policy all documents will be completed by May 31st 2021.
4. All issues related to CMSN finances are being overseen by a national group, which reviews each case and supports the PIC with the actioning of next steps. This group supports the PIC to action for each case, i.e. a progression to safeguarding, advocacy services, dept of social protection etc.
5. The national Group are developing organisational protocols to address the challenge presented when local engagement with families in relation to the need for CCoI shared oversight of CMSN finances has been exhausted. These protocols will be fully implemented by 1/6/21
6. The Head of Services is also sitting on a national HSE Community Operations subgroup for PPPG Subgroup Resident's personal property, personal finances, and possessions, which aims to develop National Guiding Principles in relation to "Resident's personal property, personal finances and possessions" for Disability Services, the learning will be applied to CCoI to ensure that each CMSN has the maximum security and control over their personal finances and personal possessions.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Following an inspection of the houses a full programme of premises and maintenance upgrades required has been compiled.
2. Minor upgrades and repairs e.g., filling holes in walls have commenced and a program of immediate improvements is being rolled out
3. Larger works e.g. painting and upgrade all buildings in the community have been costed for each house. CCoIs business case to the HSE includes the funding required to achieve this program. Contractors will be appointed with a timed schedule of works once funding has been secured.
4. A review of the furniture and soft furnishing of each house has been undertaken and a process of purchase and replacement is underway.
5. As part of a review of resident's care and support requirements the preference of residents with regard to bathing facilities will be explored and where possible arrangements will be made to ensure all Residents have access to their preferred facilities in their home
6. Where the built environment does not accommodate Residents preference the person accommodation needs will be reviewed to ensure their needs are met.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. CCoI Safety & Risk Manager conducted a review of fire safety measures, fire drills and fire registers at Kyle on 13th April 2021 an audit report and action required have been incorporated into the Improvement Plan
2. Training provided to the Team Leads by Safety & Risk Manager on 13/4/21 on the maintenance and management of fire registers.
3. The tumble dryer and washing machine have been moved from the communal entrance space to the utility room on the 19/4/21
4. A procedure for daily check and removal of lint from the tumbler dryer has been implemented from 19/4/21
5. All flammable materials have been removed from internal cupboard to secure storage on 19/4/21

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. A full review of all medication management requirements including PRN was undertaken in the community from 12/4/21 to 16/4/21
2. New standardized medication management KARDEX was introduced for all residents.
3. Daily audit of the storage and administration records for all residents was introduced by the team leads in all houses on 19/4/21. This audit is reviewed on a daily basis by the House Coordinators and team leads and any required actions addressed immediately and these actions are recorded in the daily huddle notes.
4. The governance and oversight of Residents high alert medication management requirements was reviewed, and daily clinical oversight was introduced to support the safe management of this medication
5. A medication audit will be completed on the 3rd of May.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. A review meeting has been held with Regional Safeguarding Lead & PIC & team Leads on 28th & 29th of April review open cases and a further meeting is scheduled for the 6th May. An action plan for open cases will be completed and reviewed monthly as part of

the Community Management Meeting.
2. To ensure that staff at house level are provided with a comprehensive understanding of the CMSN's safeguarding plan and their roles and responsibilities in the delivery of those plans, Applied Safeguarding Training is planned for all staff by 14th of June 2021.
3. The door lock on one Resident's front door was changed to eliminate the need to manual lock by the Resident as she enters and exits her home in order that she feels safe and secure.
4. Staffing levels have been increased and roster lines have been stabilised so that staff are familiar to Residents and are known to Residents
5. Training in applied safeguarding will be delivered in May
6. Increased clinical supports have been assigned to the community with a Clinical Support officer present at least weekly
7. The report of the SIR dealing with the retrospective inappropriate management of Residents monies has been accepted by the board at its last meeting and a plan is being put in place to arrange repayment of outstanding monies by 30/6/21.
8. The report of the SIR dealing with the care experiences of one CMSN will be brought to the next meeting of the Serious Incident Investigation Group on the 25/5/21 for review and considerations of its recommendations and findings. An action plan to address the findings will be put in place following this meeting.

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.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. The PIC, Regional Manager and National Quality & Safety Lead have developed a number of proposals which have the potential to eliminate the need for the restrictive measures currently affecting the quality of life of two CMSN.
2. The PIC is in consultation with the Residents involved and their representative regarding this proposal with a target for commencement of the transition planning by May 10th
3. All restrictive measures will be reviewed to ensure they are in line with the reviewed Restrictive Intervention Policy and an action plan to progress any required changes will be completed by 31st July 21.
4. A review meeting has been held with Regional Safeguarding Lead & PIC & team Leads on 28th & 29th of April review open cases and a further meeting is scheduled for the 6th May. An action plan for open cases will be completed and reviewed monthly as part of the Community Management Meeting.
5. To ensure that staff at house level are provided with a comprehensive understanding of the CMSN's safeguarding plan and their roles and responsibilities in the delivery of those plans, Applied Safeguarding Training is planned for all staff by 14th of 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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	30/06/2021
Registration Regulation 7(2)(b)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 3.	Not Compliant	Orange	30/04/2021

Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	01/06/2021
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	01/07/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/04/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the	Not Compliant	Orange	12/04/2021

	day and night and that it is properly maintained.			
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.	Not Compliant	Orange	30/06/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/11/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/05/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2021
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	Not Compliant	Orange	30/06/2021

	the statement of purpose.			
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	05/05/2021
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 determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/03/2021
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of	Substantially Compliant	Yellow	01/06/2021

	giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	01/06/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	19/04/2021
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	19/04/2021
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating	Not Compliant	Orange	23/04/2021

	to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	30/04/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	01/06/2021
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	Not Compliant	Orange	01/07/2021

	and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	06/04/2021