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 Ballymoney
Name of provider:	Camphill Communities of Ireland
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	11 February 2021
Centre ID:	OSV-0003633
Fieldwork ID:	MON-0031800

About the designated centre

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

Camphill Ballymoney consists of two detached houses and one dormer bungalow located in a rural community setting. Overall, the designated centre can provide residential services for a maximum of seven residents with support given by paid staff members and volunteers. The centre can accommodate residents of both genders, aged 18 and over with intellectual disabilities, Autism and those with physical and sensory disabilities including epilepsy. Facilities throughout the three units that make up this designated centre include kitchens, sitting rooms and bathroom facilities while each resident has their own bedroom.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 11 February 2021	10:00hrs to 15:30hrs	Tanya Brady	Lead
Thursday 11 February 2021	10:00hrs to 15:30hrs	Conan O'Hara	Support
Thursday 11 February 2021	10:00hrs to 15:30hrs	Conor Brady	Support

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic, and the inspectors adhered to all public health guidance with respect to infection prevention and control. All parts of this centre were included in the inspection and each inspectors inspect one house each (to decrease footfall across locations). Inspectors met with residents, staff, management, observed practice and reviewed documentation. A review of documentation took place in an office space (clean zone) removed from contact with residents to ensure compliance with public health guidance and HIQA's enhanced inspection methodology.

As part of a national provider improvement plan this registered provider had made a number of commitments to the Chief Inspector with respect to implementing improvements for residents in this centre. The inspectors noted that despite actions taken by the provider, these improvements had not yet taken place and had not translated to regulatory compliance in this centre. Inspectors found that this was due, in part, to the significant under resourced staffing levels and the lack of consistency in management structures evident in this centre.

The designated centre was made up of three houses in close proximity to each other in a rural setting. The houses were warm and homely in many parts however inspectors also found a number of premises improvements that were required. For example in the areas of residents accessibility and privacy, site water drainage and external premises issues, storage for residents belongings in bedrooms, centre upkeep, maintenance and hygiene (laundry room/bathrooms).

The main house included a 'basketry' (workshop for making baskets) accessible externally (for day service participants) and this building was also connected to the house via a bathroom which was not found to be conducive to resident privacy. The provider stated that this 'basketry workshop' was closed since the start of the COVID - 19 pandemic with no plans to reopen again (to non residents) and that the space would be re purposed accordingly.

There were seven residents living in the designated centre on the day of inspection, with one resident having recently transitioned (emergency admission) from another centre run by the provider. Inspectors were informed that this resident was living in the centre temporarily until they can return to their own home. The inspectors had the opportunity to meet with five residents over the course of the day. Two residents were present at the start of the day and were seen to be getting ready to go out when inspectors arrived. They were supported to travel to a nearby location to cut willow trees which they used for basket making. From observations by inspectors residents appeared happy and content during activities the inspectors were present for. One resident told the inspector directly that they were 'happy' living in the centre.

Staff on duty presented as familiar with the residents likes and dislikes and guided

the inspectors to ensure they could engage in an optimum manner during interactions. Residents were seen to be comfortable and at ease with the staff present and staff were warm and friendly. One staff member was observed making a hot breakfast for a resident and was continually observed to be ensuring that the resident enjoyed the experience and was also observed combing the residents hair which the resident enjoyed.

It was noted however, that there were insufficient staff on duty and the staff team were visibly under pressure as two staff members had not turned up for work on the day of this unannounced inspection. This resulted in existing staff, including the person in charge, filling in gaps and inspectors noted staff members moving between the houses over the course of the day to fulfil care and support tasks which was not best practice in terms of infection control. Also as a result of staff being deployed to other houses to provide cover, this meant that where residents should have been supported by a specific number of staff it was now reduced.This resulted in reduced supervision for residents, reduced opportunities to engage in individualised activities and residents were unable to leave the centre for activities. In one house a single staff member was supporting three residents where there should have been two staff on duty. It was apparent from engaging with residents that they have had poor consistency in staff support since the previous inspection. Residents were heard asking if inspectors themselves were members of staff or how long inspectors would be working in the centre for. An inspection of rosters and discussions with staff, residents and management confirmed a very high footfall of different staff members (relief/agency) working in the centre since the previous inspection. Inspectors also found staff turnover had been high since the previous inspection with a number of staff leaving the service.

In one of the houses, the inspector was greeted by a resident on arrival who used a combination of manual signing and vocalisation to communicate. They welcomed the inspector to their home and were happy to allow the inspector to look at their art work and collection of music CDs in their room. The resident was seen to sit at the kitchen table to engage in art which they reported enjoying and this activity was part of the residents daily routine. They were supported on occasion by an art instructor remotely via a social media platform. The resident had enjoyed engaging with a local college for literacy classes before COVID-19 and reported that they missed this. Another resident in this house was still asleep in bed and staff reported that the resident set their own daily timetable and preferred to sleep late and this was respected with no one entering their room or disturbing them until they indicated that support or company was welcomed.

In the second house, an inspector had the opportunity to meet the one resident who was living there. The resident used alternative communication methods and was observed to be content and relaxed in their home. The inspector observed the resident engaging in activities of daily living including preparing breakfast and arts and crafts. The house was decorated in a homely manner and consisted of a kitchen, sitting room, community room, office, bathroom, a resident bedroom, two staff bedrooms and a large garden to the rear of the property. There was also a self-contained apartment within the unit of an en-suite bedroom and a living area which contained a cooker. The upstairs of the unit which provided store rooms was

in the process of being renovated at the time of the inspection. As noted above it was observed that there was insufficient staffing levels in the unit. On the day of the inspection one relief staff member had not turned up for work. The inspector observed two staff members arriving from the other units to provide support in the house and to administer medication.

While residents were relaxed and engaged in activities they reported to enjoy, the reduced level of staffing has reduced resident choices on a daily basis. The lack of consistency within the staff team has also led residents to question who would be present on each day to support them. In the next two sections of the report the specific regulations viewed by inspectors are outlined and the impact on the 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, substantive provider led improvements were required across all Camphill Communities of Ireland designated centres. This national improvement plan was submitted by Camphill Communities of Ireland in October 2020. Due to the seriousness of the regulatory concerns regarding both the capacity and capability of the registered provider and the quality and safety of care and support delivered to residents, the implementation of this national plan is being monitored by the Chief Inspector on a monthly basis. This inspection formed part of this national monitoring programme of Camphill Communities of Ireland.

This unannounced risk based inspection was completed as a result of concerns relating to the governance and management arrangements in the centre as the Chief Inspector had become aware of a number of changes to the local management team in the designated centre. This inspection found that overall there had been very limited improvements since the previous inspection. This centre had not moved towards regulatory compliance in the areas inspected despite the providers national improvement plan being in place.

At this centres previous inspection (01 July 2020), inspectors had raised concern regarding the size of the remit of the then person in charge. Inspectors found that the provider subsequently made a number of changes to the individual holding this role. In total inspectors found that there had been five changes to the person in charge reported since the last inspection, seven months previously. The provider had not submitted any formal notification to the Chief Inspector or the required documentation for three of these named individuals. This meant that it was not possible for inspectors to make a judgment as to whether these individuals who were holding this position had the required qualifications, garda vetting, skills and experience to fulfil the role of person in charge. The person in charge for the centre

on the day of inspection reported to inspectors that they were in the post of person in charge for 4 weeks. The person in charge who was notified to the Chief Inspector (a different person) was determined to be fulfilling a Regional Manager role in the organisation on the day of inspection. Inspectors noted their regulatory concerns to the registered provider at preliminary feedback in that this approach did not give the appropriate levels of assurance regarding the governance of the centre particularly in the context of the inspection findings. Inspectors noted that the person in charge notified to the Chief Inspector should be the person fulfilling the role in practice and that this person should be the one inspectors find managing the centre. This was not found to be the case on this inspection. The provider stated at preliminary feedback that all of the regulatory information required for the person in charge would be submitted as a matter of priority following this inspection.

There was a new management structure on the day of inspection and while lines of authority and accountability were in place, this was less apparent to staff who spoke with the inspectors about the number of changes there had been in the centre and their lack of clarity on who fulfilled specific roles. The provider had completed two six monthly unannounced visits as required by the regulations since the previous inspection. Actions were seen to have been set, however, on review of these it was clear that they remained incomplete. An external review of the centre had also been completed and the inspectors noted that areas of risk for residents had been identified in this, such as a risk of financial abuse, however new systems had not yet been put in place to mitigate against this. Management meetings had been occurring in line with the provider's national action plan, however, a review of minutes from these meetings and plans showed that actions identified had not been implemented. There were currently no regular effective systems of audit and oversight in place in the centre to ensure implementation of commitments made by the provider.

It was apparent that the management team in place found locating some of the requested documentation for inspectors difficult on this inspection and inspectors requested that some documentation was sent following the inspection as it could not be located on the day. Staff from another of the providers centres had to attend to support the management team which resulted in the crossing of personnel between locations during the pandemic.

The registered provider was aware that there were insufficient numbers of staff to meet residents assessed needs. This was outlined on the service risk register and the person in charge told inspectors the centre was operating at 40% of their staffing WTE (whole time equivalent) and that they were heavily reliant on agency/relief staff to cover shifts. Additionally, the skill-mix of staff did not meet the care and support needs of residents, with unpaid volunteers who lived in the centre (as part of the provider's life sharing model) being heavily relied upon too with the front line care and support of residents. The provider and person in charge were endeavouring to cover gaps in the roster with the use of consistent agency staff. However as evident on the day of inspection this was proving a difficulty as two staff did not report for duty. Inspectors reviewed staff personnel files and found that they did not contain all of the information, as required in Schedule 2 of the

regulations.

The training matrix in place in the centre was not current and there was no up-to-date system for ensuring that staff were in receipt of up-to-date training or refresher training. While inspectors could see that some certificates were in place in staff files this did not correspond with what was on the training records. It was not possible on the day of the inspection for the provider or person in charge to give assurances that all staff on duty had received all mandatory training as required. For example, a staff member identified to give medication as observed by inspectors was recorded in the provider's system as being overdue their medication refresher training. The inspectors reviewed a sample of staff supervisions and noted these were not taking place as required.

The registered provider had ensured the development of a new service provision agreement between the organisation and the resident. This document detailed the services and supports that were to be provided including any fees to be incurred. On review of a sample of resident files it was seen that a new service provision contract was in place for all residents, and these had been signed. However, a recent admission to the centre had occurred due to an emergency in another centre and was found to have been unplanned with all of the resident's plans and assessments referring to their previous placement as opposed to their current one.

Registration Regulation 5: Application for registration or renewal of registration

An application for the renewal of registration of this centre had not been received as required. The centres current registration expires on 21 July 2021 and the application is overdue.

Judgment: Not compliant

Registration Regulation 7: Changes to information supplied for registration purposes

The provider had not submitted the documentation pertaining to persons fulfilling the role of person in charge as required to the Chief Inspector within the time lines required by regulation.

Judgment: Not compliant

Regulation 15: Staffing

The provider had completed a staffing review in this centre and identified that there

were less than 60% of the staff WTE that was required to meet residents assessed needs. Agency staff were in use to make up the shortfall where possible however on the day of inspection the level of staff support was not as identified on the roster and in one house residents had half of the available staffing team on duty.

A sample of Schedule 2 files was reviewed by inspectors and while they contained the majority of the information as required by the regulations, one was missing a second reference and the information available on agency staff files were incomplete.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider and person in charge had no systems in place to ensure that staff were in receipt of mandatory training and refresher training as required. In reviewing the information that was available three staff were overdue fire safety refresher training, two staff required safeguarding refresher training and eight were due refresher training in the safe administration of medication with one of these due since 2018. Staff supervisions were not taking place.

Judgment: Not compliant

Regulation 23: Governance and management

Following the last inspection of this centre there were a number of actions identified which the provider has not completed despite assurances as part of the National monitoring programme. These included for example, implementation of new processes such as resident money management assessments and systems of oversight or recruitment of staff vacancies.

Audits were not consistently completed as planned and where some had been completed there were actions identified that remained outstanding.

The provider had completed six monthly unannounced visits to the centre within the period since the last inspection.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had ensured the development of a new service provision agreement between the organisation and the resident. This document detailed the services and supports to be provided including any fees to be incurred. On review of a sample of resident files it was seen that a new service provision contract was in place for all residents, and these had been signed.

An admission to the centre did not take place in line with the centres statement of purpose and function and the information/personal plans in place to support this resident had not been updated since their previous placement.

Judgment: Not compliant

Quality and safety

The person in charge and the staff team in the centre were found to be trying to ensure that residents were in receipt of a safe service and inspectors noted that the residents they met with, presented as reasonably well cared for on the day of inspection. However, this was not consistently the case due to the under-resourcing of the centre, and as previously mentioned the standard of monitoring and oversight of care and support. Inspectors found that the provider has not ensured the implementation of assurances made to the Chief Inspector at centre level.

The premises was found to be reasonably warm and comfortable inside however, they also presented as requiring substantive maintenance, cleaning and repair in all three houses. Inspectors noted holes in walls, areas requiring redecoration, flooding/drainage issues externally, woodwork such as window sills and banisters that required maintenance, bathrooms/toilets and laundry room requiring maintenance and cleaning. While residents bedrooms were personally decorated and clean there were items that needed repair within these too. Storage space was an issue for some residents with supportive equipment and incontinence wear stored inappropriately in their bedrooms. The new person in charge had tried to make some improvements, such as fixing a fence or putting in shelves in one of the houses (so files could be removed from the floor) however, it was acknowledged that substantial further repairs were required. A number of hazards in the external areas were apparent with flooding, drainage holes, septic tank access, broken glass, tools and unlocked sheds to the rear of the property. In one property, more than three quarters of the external site/gardens were inaccessible to residents. A staff smoking area was located at the front of the house next to the front door.

Regarding risk management and safeguarding inspectors found further improvements were required in both areas. Inspectors reviewed risk in the context of risk impact and likelihood based on the providers own risk management system, which was requested at the outset of this inspection. Inspectors found that there were 17 risks outlined on the centres own risk register with 12 risk rated orange by the provider. These included:

- Risk of non-compliance with regulatory standards due to the unsuitability of premises.

- Risk of non-compliance with regulatory standards due insufficient resources to provide the required support for residents.

- Risk of non-compliance with regulatory standards due to the inability to recruit and retain staff with the required skill set and qualifications to work with and support residents.

- Risk of harm to residents due to staff errors and omissions when in the care of Camphill Community Ballymoney.

- Risk of failing to comply with regulatory standards due to infrastructural deficits within the systems of Camphill Ballymoney.

- Risk of environmental contamination.

Inspectors could see efforts on the part of the provider to try to move towards a better system of risk oversight and management. For example, the commencement of a risk register. However, the recorded control measures in place for the above risks were either not in place or ineffective. The inspection of this centre found that some risks were either not identified or assessed (e.g., environmental hazards, resident finances) or where they had been assessed (staffing/resourcing, infection control/laundry) the control measures highlighted as necessary did not demonstrate appropriate risk management or were simply not implemented. In addition, the inspectors found that the named risk owner was a person in charge who no longer worked in the centre. Ultimately while a number of risks were identified, they were not being managed.

A sample of active safeguarding cases were reviewed, whereby alleged abuse had occurred. Inspectors found in some instances the required safeguarding actions had been taken by the provider to ensure resident safety, but the required documentation and paperwork had not been fully progressed. In another case reviewed, the required action had not been taken with a resident recorded as requiring/recommended further clinical input/counselling. Inspectors found that this had not being provided/pursued by the provider for this resident. Inspectors found that complaints, incidents and safeguarding were all merged and that as such a clear system of evidenced follow up and intervention was not in place. Residents financial safeguarding was found to be compromised in this centre. In a review of residents finances, two residents finances were checked by inspectors and both did not tally with the recorded amounts in their personal cash records (€3 and €4 down). The providers new system for recording and checking resident finances was not found to be operational in the centre. Daily checks of resident finances were not occurring in two locations inspected. Residents did not have money management assessments reviewed or updated using the providers new policy and processes and therefore did not have up-to-date money management plans in place. A review by an external agency arranged by the provider had specifically noted that residents were at risk of financial abuse due to governance and oversight of their finances and inspectors noted that despite this, changes to the systems in place had not been

implemented. At the previous inspection (1 July 2020), inspectors highlighted that a financial safeguarding matter for one resident required further attention and it was noted that this remained outstanding/unresolved on this inspection. Due to serious national issues regarding the safeguarding of resident finances across Camphill Communities of Ireland, the provider had specifically assured the Chief Inspector that financial safeguarding would be addressed as a matter of priority across their centres. This was not found to be have been completed in this centre.

The systems in place for fire safety management required improvement. The inspectors found that there was evidence of regular fire evacuation drills for two of the units. However, there was no evidence of fire drills taking place in one unit with a recently admitted resident. In addition, a personal emergency evacuation plan (PEEP) in place for this resident was not centre-specific and did not appropriately guide the staff team in supporting the resident to evacuate. The arrangements in place for fire containment and evacuation also required review. For example, in a self-contained apartment, which was vacant at the time of the inspection, a cooker had been installed in the living area. It was not evident that suitable containment measures were in place between the living room and bedroom. In relation to evacuation, it was not evident that there was adequate arrangements in place to safely evacuate the self contained apartment. In another of the houses doors between the utility room, kitchen and living room required review as there were gaps where the doors did not fit with in the frame. Where a resident lived in a self-contained apartment their exit point was immediately adjacent to the utility room and concern was expressed that a review of safe evacuation processes were required. Another door (adjoining the centre to a basketry via a bathroom) had a square of the door removed to serve as a 'cat flap door' rendering it ineffective for fire containment. The inspectors found that the centre had fire safety equipment in place throughout the centre, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required.

The provider had not ensured that appropriate systems were in place for the prevention and management of risks associated with COVID-19 and other areas of infection prevention and control. Personal protective equipment (PPE), including hand sanitisers and masks, were available in the centre on the day of the inspection. While there were infection control guidance and protocols in place, the inspectors observed that in one house temperature checks were not being completed for all residents and staff in line with the provider's policy. In addition, as noted some staff members were observed going between houses due to inadequate staffing arrangements with staff also coming from another centre and moving between houses in this centre. Some staff were observed not wearing masks when inspectors arrived on this unannounced inspection only putting on their face masks after the arrival of inspectors. In one of the houses the inspector was not asked to comply with any of the systems in place on arrival/entry such as hand hygiene or temperature checks. The provider had identified other areas of risk in this centre such as the requirement for water quality testing to protect against Legionella and this had not yet been put in place nor were there systems to run or flush water.

The practices in place for the management of medication required improvement. In one unit, the inspector reviewed a sample of medications and found one medication

should have been disposed of based on its opening date. As noted earlier, it was observed that a staff member administered medication in one unit while requiring medication refresher training.

Regulation 12: Personal possessions

The providers plans regarding residents financial management had not yet been implemented in this centre. There remained discrepancy between recorded amounts of money for residents and the actual amount present.

Records of resident personal property were not consistently in place and where they were they had not been updated in some cases since 2018.

Judgment: Not compliant

Regulation 17: Premises

The houses comprising this designated centre all required maintenance both internally and externally in terms of suitability, layout, accessibility, redecoration and cleanliness.

Judgment: Not compliant

Regulation 26: Risk management procedures

While a new risk management framework was developed it was not being implemented at centre level. Furthermore a number of clearly identifiable risks were not being managed in this centre - monitoring/supervision, staffing/resourcing, safeguarding, finances, infection control, premises.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had not ensured that appropriate systems were in place for the prevention and management of risks associated with infection.

Judgment: Not compliant

Regulation 28: Fire precautions

The systems in place for the containment of fire and evacuation of residents required improvement.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The practices in place for the management of medication required improvement. In one unit, the inspector reviewed a sample of medications and found one medication should have been disposed of based on its opening date. As noted earlier, it was observed that a staff member administered medication in one unit while requiring refresher training.

Judgment: Not compliant

Regulation 8: Protection

Recommended safeguarding actions had not been followed up and financial safeguards had not been completed. Inspectors were not assured that residents and/or their finances were appropriately protected in this centre.

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	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Camphill Ballymoney OSV-0003633

Inspection ID: MON-0031800

Date of inspection: 11/02/2021

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: An application for the renewal of registration has been submitted since the date of inspection, submitted on the 12/2/21.	
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: A Permanent PIC has been appointed to the Community of Ballymoney and the necessary PIC documentation has been submitted as of the week of the 15th February 2021.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing:	

The Provider has been successful in recruiting and to date has increased the communities by two WTE.the provider is currently in the process of recruiting to 100% WTE. To be completed by 1st May 2021.
The Provider has completed a comprehensive needs assessment for all residents of Ballymoney Community and has identified the necessary skill mix of the support team for this Community. Recruitment will be in line with the resident's needs.

The Provider will complete all Schedule 2 files for Camphill Employees and Agency staff by 1st April 2021.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training Matrix to be updated to reflect all mandatory training completed by team members and to alert the PIC to essential training or vetting required prior to its expiry date. This will be audit by CCOI National HR team to ensure that it is accurate.

All staff will have fire safety, safe- guarding and safe administration of medication completed by 1st April 2021.

The PIC has developed a Supervision Schedule in line with CCOI National Assurance Plan.

To be completed by 1st April 2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider has supported the PIC by providing an additional staff resource to support the PIC to ensure all team members understand and implement all actions identified in CCOI National Provider assurance programme. A senior manager of CcoI has been allocated to support this centre to achieve compliance in line with targeted action plans from 24/3/21

Professional Cleaners have been contracted to perform a deep clean of all houses. A cleaning roster specific to each house has been created capturing every room. All team

members were trained on this system on the 18 March 2021. This will be checked and signed daily by House Co-ordinator and audited by PIC.

Training was provided to the Ballymoney team and PIC in the new CcoI CMSN policy and SOP for the management of finances and personal possessions. By the 26th March 2021, All CMSN's will have transitioned to the new systems and repeat Money Management Assessments and plans will be created will be in line with the CCOI New residents financial policy.

PIC, HC & Interim Manager with Regional Manager are meeting weekly and completing actions identified from audits. An internal unannounced inspection programme has commenced across CcoI and a range of on site and remote audits are being rolled out

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

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The PIC will engage the new resident in a process of updating their contract in line with their move to Ballymoney Camphill Community. The PIC will ensure that the resident's information/personal plans will be updated to reflect their relocation to Ballymoney.

To be completed by 1st April 2021.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The PIC will ensure daily checks are completed of the Residents Finances. The local community management team will ensure that the providers plans regarding resident's financial management are in place by the 1st April 2021. Uploading Residents Assets Register and Money Management Assessments onto SharePoint in order for National oversight.

Records of Residents Personal Property to be updated by 1st April 2021.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Cleaning rosters will be checked daily by PIC. Maintenance work and creating of suitable storage space will be completed by 1st August 2021.

External hazards such as drainage holes, flooding areas, septic tank access, will be actioned and completed by 1st May 2021. The unlocked shed will be locked and the broken glass cleaned up and the Smoking Area relocated away from front of the house by the 10th March 2021.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
On the 26th February 2021, PIC and National Health, Safety & Risk Lead revised Ballymoney risk register.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
PIC will monitor and ensure that all team members are wearing masks in line with CCOI Policies and Procedures. PIC has implemented a temperature check template that requires all Team members and residents (with their consent) to check and record their temperatures twice daily and the PIC can audit this weekly.

A House Folder with all Daily checks has been introduced to ensure that all team members are able to access Daily, Weekly & monthly Health and Safety checks such as checks for Legionella.

Recruitment is progressing to enable CcoI to deploy staff to an assigned house, minimizing the crossover of staff between houses. Full team will be in place by May 2021.

PIC will ensure that all team members and visitors to the community will comply with Infectious Control CCOI Systems. This will be discussed at Team Meetings with all team members to ensure compliance.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
PEEP has been updated for new resident and fire drill completed in all three houses.
CCOI National Maintenance team are currently actioning the building works identified in this HIQA Inspection. These works should be completed by 1st August 2021

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 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
PIC will oversee weekly medication audits with actions to be followed up in Team meetings.
Training matrix to be updated to reflect full audit of Schedule 2 Files.

To be completed by 1st April 2021.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The PIC will ensure daily checks are completed of the Residents Finances and that actions from audits or Inspections are completed in a timely manner. The staff have been trained in the new CMSN finances and personal possessions policy and SOP, and the community will fully implement the new requirements for operation and internal controls by 1st April 2021.

A new complaints policy and system has been introduced in CCoI and the PIC will undertake training in the operation of the new system on 26th March 2021 all local complaints are managed through this system and is overseen by a CCoI complaints Officer who reports to the Head of Service monthly.

Training is to be provided to the PIC in the management and operation of the various quality and safety management systems 30/03/2021 March 2021 to ensure that incidents, complaints and safeguarding are managed effectively and that follow up interventions are evidenced.

A safeguarding action plan was put in place on 22/03/2021, as details the schedule to review all current safeguarding plans.. The implementation of this plan will be delivered by the Designated Officer, managed by the PIC and overseen by the Regional Manager and Regional Safeguarding Lead.
The PIC will complete a monthly review of safeguarding incidents, informed by the Designated Officers monthly analysis of safeguarding incidents, with appropriate escalations and/or referrals to be made as identified. Analysis findings and actions proposed/taken to be presented to the monthly Community Managers meeting attended by regional managers from CCoI Clinical, Operations and Safeguarding Teams to ensure cross functional input and oversight
Safeguarding incidents and open safeguarding plans will be discussed at weekly staff team meetings to ensure the care and support team are aware of the Open Safeguarding Plans and the safeguarding measures to be maintained by them for the community members with supports whom they support.
An audit of the safeguarding files will be completed by 15/04/21 with the support of the CCoI National Safeguarding Team. Required documentation and paperwork outstanding will be progressed by 30/04/21.
PIC to request from 'Forensic Psychology Ireland' a summative update on counselling, as was in place January 2020 to April 2020, in respect of the resident identified to be in need of clinical input/counselling. To be requested by 26/03/21.
A multi-disciplinary meeting will be convened by 30/04/21 to address the counselling/therapeutic needs of the resident whom has had clinical/counselling input recommended, to include her former counsellor who had suspended sessions since April 2020 due to Covid-19. The meeting to explore the most appropriate way to meet the resident's to therapeutic needs

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	12/02/2021
Registration Regulation 7(2)(a)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event notify the chief inspector in writing, within 10 days of this occurring, where the person in charge of a designated centre has ceased to be in charge.	Not Compliant	Orange	12/02/2021
Registration Regulation 7(2)(b)	Notwithstanding paragraph (1) of	Not Compliant	Orange	22/02/2021

	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.			
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	19/03/2021
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	01/05/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care	Not Compliant	Orange	19/03/2021

	and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	01/04/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	01/04/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	19/03/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the	Not Compliant	Orange	18/02/2021

	designated centre are clean and suitably decorated.			
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	19/03/2021
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	12/03/2021
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	12/03/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and	Not Compliant	Orange	19/03/2021

	safety of care and support in the designated centre and that such care and support is in accordance with standards.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	18/03/2021
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Yellow	12/02/2021
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	Not Compliant	Orange	01/04/2021

	system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	26/03/2021
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	01/08/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/08/2021
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire	Not Compliant	Orange	01/08/2021

	alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
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 of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	18/02/2021
Regulation 29(4)(b)	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 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.	Not Compliant	Orange	18/02/2021
Regulation	The person in	Not Compliant	Orange	18/02/2021

29(4)(c)	charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	12/02/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	12/02/2021