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 Ballybay
Name of provider:	Camphill Communities of Ireland
Address of centre:	Monaghan
Type of inspection:	Short Notice Announced
Date of inspection:	25 August 2020
Centre ID:	OSV-0003603
Fieldwork ID:	MON-0030224

About the designated centre

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

Camphill Community Ballybay is a residential service that provides care and support for 17 adults with an intellectual disability. This designated centre is located on a large campus including a farm, several workshops, outbuildings and five separate residential buildings for residents and volunteers. The provider, Camphill Communities of Ireland, operate a unique approach to service provision that is aligned to the Steiner model of care, communal living and social pedagogy. Residents living at this campus participate in activities which support the overall ethos of the service and may undertake work-based activities on the campus, supported by staff and short term co-workers, who work in a voluntary capacity. Residents are also able to access the local community and services in the local town.

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
Tuesday 25 August 2020	10:00hrs to 16:00hrs	Christopher Regan-Rushe	Lead
Tuesday 25 August 2020	10:00hrs to 16:00hrs	Eoin O'Byrne	Support

What residents told us and what inspectors observed

Inspectors met with and interacted with five of the residents living in the designated centre on the day of inspection. The inspectors spent some limited time observing the interactions between staff and residents, and met with three residents at the end of the inspection to hear their views on the service they were provided.

During the course of the inspection, an inspector observed two residents being supported in the day room of their service. Staff were seen to be positively engaging with these residents, one of which was being supported to undertake an activity of interest to them. Residents who met with the inspectors spoke very positively of the service they were receiving and described their work on the farm or in tending to the vegetable gardens over the course of the morning. One resident spoke of the things they preferred to do and some of the things they preferred not to do, and it was evident that they were being supported by staff to choose how they spent their days.

One resident spoke very positively about the support and the services available to them at the designated centre, which was helping them to live a life of their choosing.

The inspectors observed that the relationships between the staff, co-workers and residents was very warm and respectful throughout the course of the inspection.

Capacity and capability

Prior to this inspection, Camphill Communities of Ireland had been required to submit a number of formal assurances to the Chief Inspector regarding the safeguarding arrangements for residents and the safety and quality of care delivered across a number of their designated centres. Following a meeting with the registered provider in HIQA Offices in December 2019, the provider was required to submit a plan of specific actions they would implement to ensure improvements in the quality and safety of care and support to residents, including assurances that both management and staff had the knowledge, skills and ability to effectively meet residents' needs. This plan also included specific assurances regarding resident safeguarding and financial safeguarding.

While the residents reported that they enjoyed living in the centre, inspectors found that, overall, the provider had failed to ensure that an effective governance system was in place in the centre. This meant that there was a fundamental

failure to comply with regulations across a number of areas. For example, a failure to ensure that residents were paying the correct contributions due to the lack of rigorous financial controls in the centre and a failure to ensure that staff were being guided by policies and procedures which had been subject to regular review, and updated to ensure that they reflected best practice guidelines. In addition, while the person in charge was working towards a suitable management qualification, the provider had failed to ensure that they had the required qualifications in place prior to making the appointment. Improvements were also required to ensure that all necessary notifications were being submitted to the Chief Inspector as per the regulations. The inspectors found that the provider had failed to submit quarterly notifications as per the regulations since January 2020, and in doing so failed to notify the Chief Inspector of restrictive practices in place in the designated centre. Improvements were also required to the provider's management of adverse incidents and this will be discussed in more detail in a later section of the report.

Recently, the person in charge submitted nine safeguarding notifications to HIQA relating to the potential financial overcharging of residents for their placements at the designated centre. The provider and the person in charge made this discovery when they were in the process of introducing new contracts of care. It was noted that there were discrepancies in the amounts of money being deducted from nine of the 17 residents' accounts. These nine residents were found to be making additional contributions above and beyond the fees agreed in their the contracts of care, potentially over a significant number of years. While the provider understands that these additional contributions had been agreed with the residents' representatives, the residents had not been consulted or given their consent. At the time of the inspection, the provider had initiated an investigation into the over payments and this was reported as ongoing.

As demonstrated in this report, there was an abundance of evidence that the provider had consistently failed to ensure that there was sufficient oversight and monitoring of the service to ensure that any gaps or weakness identified in the service were resolved. For example, the provider had completed the required annual review and unannounced visits to the centre. This had led to the detection of significant areas for improvement. While some actions had been identified, there was no evidence of any work being progressed against these actions.

The provider is required to ensure that they maintain relevant policies and procedures - in accordance with schedule 5 of the regulations, that are subject to review at least every three years. The inspectors reviewed 35 separate policies and found that for the majority of these the provider had set their own review cycle of two years. However, in reviewing these policies the inspector found that

· two had not been subject to approval prior to being made available to staff in the centre, and there was no evidence of what period of practice these were intended to cover

· 30 were past the required provider's review date of two years. Of these, 16 were last reviewed over three years ago while two were found to have been last

reviewed in 2014

· three policies had been reviewed and approved and were deemed current.

Critically, this meant that the provider was failing to ensure that staff were being guided by clear and up-to-date policies. This posed a significant risk to the quality and safety of the service and meant there was a potential risk that staff would follow a policy or practice that was not in line with current best practice. In addition as mentioned later in this report, there was evidence of gaps in the information available to guide staff practice in some of these policies, and in particular within the infection control policy.

Since the last inspection the provider had appointed a number of staff to work in the service, some of whom had previously been long-term support workers. However, there was evidence that there was still some over reliance on volunteers to participate in the staff rota. For example, one volunteer had been scheduled to provide sleeping night cover on a regular basis in one of the houses on campus, while another was observed to be scheduled on duty for 56 hours in one week. While there was a planned and actual roster, this did not, in all instances, include the start and end times for all people scheduled on duty - with some staff being recorded as in or out, while others had start and end times. In addition, where volunteers had been scheduled as being on a day off, the inspector noted that they had also been scheduled to provide back up cover on the roster, in the event that this was needed. This meant that the provider had not ensured that there were sufficient numbers of staff on duty at all times required and that they were using the volunteers to complete core staffing functions. This is further supported by evidence that these volunteers were being trained in tasks such as the administration of medication or emergency medication.

The inspector completed a review of the staff training matrix and found that of the 51 staff and six volunteers recorded on the matrix, that there were significant gaps in the completion of training. For example:

· 22 of the 51 staff on the training matrix had not completed the introduction to infection control training, while three (half) of the volunteers had not

· Seven staff had not completed training in the use of PPE (personal protective equipment), while one volunteer had not.

Overall, of the 31 courses identified on the matrix, each course had gaps where staff had not received the training. In addition, some staff were recorded as being overdue for refresher training for three of these courses. This was discussed with the person on charge on the day of the inspection and it was noted that the training matrix does not include details of what training staff of a particular grade or background required. The inspector found that this was a similar situation for volunteers, where some had completed some of the courses while others had not. This meant the provider or the person in charge, could not easily demonstrate to the inspector that each member of staff on duty had the necessary skills or had received the necessary training in order to support the residents in the centre.

The provider had ensured that all the information required by schedule 2 of the regulations was in place for each member of staff, prior to their employment commencing. While the provider required all staff to have an An Garda Síochána vetting check completed every three years, it was noted on the staff training matrix that this had not occurred for four staff. The provider had ensured that all records required for volunteers were in place prior to their commencement at the centre.

Regulation 14: Persons in charge

The provider had failed to ensure that the person in charge met the requirements of the regulations. The provider was required to take immediate action to ensure that a person in charge who possessed the relevant qualifications was appointed.

Judgment: Not compliant

Regulation 15: Staffing

While the provider had appointed a number of staff since the last inspection, there was evidence that there was still some reliance on volunteers to participate in the staff rota. This meant that the provider had not ensured that there were sufficient numbers of staff on duty at all times required.

The staff roster required improvement to ensure that this included the start and end times for all staff working in the centre each day.

While there is evidence that the provider had all the necessary schedule 2 information in place, the training matrix highlights that the Garda vetting clearance for four staff members had not been renewed every three years per the provider's requirements.

Judgment: Not compliant

Regulation 16: Training and staff development

There were a number of significant training gaps noted on the staff training matrix

for example, in areas such as infection control, safeguarding and fire safety. There was also evidence that some staff training had lapsed.

Judgment: Not compliant

Regulation 21: Records

The records which the provider was required to have in the designated centre, such as information about the residents and schedule 2 information, were in place.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to ensure that the governance and management arrangements in this centre were sufficient to ensure that the service was being effectively monitored, maintained to a good quality, was appropriately resourced and that residents were being kept safe from harm at all times.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Contracts of care reviewed on the day of inspection did not reflect the contributions being paid by the residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which included the majority of the information required by the regulations. However, this did not include all of the information from the certificate of registration as required by the regulations.

Judgment: Substantially compliant

Regulation 30: Volunteers

The provider had a number of volunteers working in the designated centre. The provider had ensured that suitable Garda vetting, and where necessary additional police checks from countries where the volunteers had lived, were in place prior to the commencement of these volunteers. The volunteers had a description of their duties and were noted to have regular supervision sessions.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had failed to notify the Chief Inspector of certain restrictive practices in place in the centre. For example, during the inspection, the inspector noted that there were window restrictors in use in one house. In addition, the provider had failed to submit quarterly notifications at the required intervals to the Chief Inspector.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider had failed to ensure that the policies required by the regulations were being maintained in accordance with the regulations.

Judgment: Not compliant

Quality and safety

Residents living in this centre appeared to be happy and well cared for. However, there were areas noted during this inspection where significant improvements were required to the systems, process and practices in the centre to ensure that the service was safe. Of particular note, infection control practices needed to improve to

ensure that the risk of an outbreak in the centre was minimised.

While the provider had introduced a number of key procedures in relation to infection control as a result of the COVID-19 pandemic, the provider's overarching infection control policy lacked sufficient detail to guide and support staff in the effective management of infection control matters. For example, this did not include any details on common infections, such as seasonal flu or the management of MRSA. It also failed to guide staff on the appropriate use and storage of key equipment, such as mops and cleaning cloths, to prevent the risk of cross contamination of an infectious disease.

In reviewing the provider's arrangements for the management of COVID-19, it was observed that the provider had put a number of controls in place. For example, there were sufficient supplies of personal protective equipment (PPE) and staff and residents were seen to be wearing surgical masks when they were less that two metres apart. There was a check point at the entrance of the campus, requiring all visitors to sign in and undertake appropriate hand hygiene tasks. There were also reminders to visitors to wear masks. However, during the inspection, it was noted by the inspectors, that staff were not maintaining appropriate social distancing and there were a number of occasions where residents and staff were in direct contact with each other. For example, on a number of occasions staff would ask residents to high five. The inspector noted that after such occurrences the staff member did not attend to hand sanitising tasks. Furthermore, staff did not have access to a personal supply of hand sanitiser for when such spontaneous contacts occurred. In addition, during a walk around of the centre, the inspector noted that while there were an abundant number of bathrooms and toilets with hand washing facilities, the provider had failed to ensure that soap or hand sanitiser was available in each of these.

The provider's risk management policy and procedure was out of date and had not been subject to review, as required by the regulations. The policy did include the required elements as set out in the regulations. However, there was evidence that risk management processes were not effective in leading to actions that reduced or mitigated the risk, particularly where there were risks posed to residents, such as in the effective management and support of behaviours of concern. In addition, the provider had failed to appropriately assess the risk that out of date policies and procedures posed to the safety of both their staff and residents and to take timely corrective actions to mitigate this risk. The inspector also noted cracked or missing tiles in a number of the bathrooms used by both staff and residents. In one bathroom, this was noted to be at the floor level in a level access shower, which posed both a risk of injury and a potential infection control risk. Neither of these risks had been suitably risk assessed and it was evident, due to the discolouration, that the tiles had been cracked or missing for a significant period of time.

The premises was made up of a series of buildings. During a walk around of the centre, the inspector noted that the decoration and furnishing in the centre was dated. In a number of areas in one house on the campus, the inspector noted that, where door sets had been changed, the provider had not repainted the areas of exposed concrete. This meant that maintenance tasks looked unfinished and did not

provide residents with the quality of environment they should expect.

The inspector reviewed a sample of residents' information and found that personal plans had been developed. The plans, however, required improvement to ensure that they outlined the supports required to maximize personal development for residents. The provider had identified this prior to the inspection and was in the process of improving the personal plans. While there was evidence of individual goals being set for residents, inspectors found that there was no documentation to demonstrate if these goals had been completed. Improvements were required to the provider's arrangements for monitoring residents' goals in regards to their progress and achievement. Inspectors also noted that residents' goals had been set prior to COVID-19 restrictions and there was no evidence of residents being supported to review, adapt or to set new goals during this period.

The provider had prepared a residents' guide that included the necessary information as required by the regulations. The provider had also ensured that residents had access to appropriate healthcare. A review of documentation demonstrated that residents had access to a local general practitioner (GP) and were supported to attend appointments. There was also evidence of residents accessing allied healthcare professionals where required.

Analysis of the centre's adverse incident log showed that there were regular occurrences of residents presenting with behaviour that challenges in the centre. There were a number of recorded incidents where residents had impacted negatively upon one another through verbal and or physical aggression. The inspector reviewed a support plan that had been developed to reduce the impact of some of the behaviours and found that the provider's response had failed to ensure that all alternative measures were considered before an environmental restrictive procedure was put in place. This environmental segregation was being used as a routine procedure to ensure that some residents did not interact with one another or spend time in the same room as one another despite these residents living together.

The inspectors reviewed a sample of behavior support plans that had been developed for residents and found that the plans were under regular review by the staff team. These plans had, however, been developed locally by staff without the guidance of a behavior support specialist. The inspector found that incidents of challenging behaviors were occurring on a regular basis and that there were improvements required to identify and alleviate the cause of residents' behaviour.

The provider had started to review behaviour management systems following the recent appointment of a regional clinical lead. The inspector observed that recording sheets had recently been introduced for some residents in an attempt to gain a better understanding of their behavioral support needs, but that this process was in its infancy and had yet to lead to a reduction in behaviour that challenges.

Prior to the inspection, the provider had submitted nine notifications that stated that the provider had failed to effectively safeguard residents' finances. The person in charge had initiated an investigation into the safeguarding concerns as per the

regulations. This investigation was ongoing at the time of the inspection. The inspector reviewed correspondence between the provider and residents' representatives where the provider had acknowledged the overpayment the nine residents had been making and requested family members to alter the standing orders to ensure that residents' payments were correct.

A sample of residents' financial records were reviewed by the inspector. There was evidence of financial risk assessments being completed for residents. However, a more detailed account of items purchased or spending was required for some residents in order to ensure full transparency.

The provider had ensured that there was a fire safety management system in place. There were, however, improvements required to aspects of the system. A review of fire safety records for two of the buildings that made up the centre highlighted inconsistencies in the provider's arrangements for evacuating all people in the centre in the event of a fire. While regular fire drills were being carried out for both houses, one of the house's records were unclear and did not clearly state which staff, volunteers, or residents had participated in a drill. The available records showed that the provider had also failed to ensure that a drill for this house with the minimum staffing level and the maximum resident occupancy had been completed. In contrast, a review of the second house's fire records demonstrated adequate fire evacuation arrangements and effective recording of fire drills.

The provider had provided suitable fire fighting equipment, however; inspectors found that improvements were required to the maintenance of all fire fighting equipment, including fire blankets.

The medication management systems in regards to the safe administration of medications to residents required improvement. A review of records highlighted that there had been 13 medication incident forms completed in 2020. Many of these incidents related to medication being spilled by staff members, however; the provider had notified the Chief Inspector of an adverse medication incident where a resident had received double the amount of their prescribed medication resulting in hospitalisation. It was also noted that on one occasion a resident had gained access to another resident's medication and consumed this. There was evidence of these adverse incidents being reviewed but these reviews were not leading to reductions in incidents taking place.

There were further improvements required to ensure that the correct dosage of all PRN (when required) medications were listed on all residents' medication administration sheets. This was highlighted to the house coordinator on the day of inspection.

Regulation 12: Personal possessions

Improvements were required in the management of residents' finances. The inspector reviewed a sample of financial records for residents and found that there

continued to be discrepancies in the residents' petty cash balances.

Judgment: Substantially compliant

Regulation 17: Premises

The provider had failed to ensure that the premises was being maintained to a suitable standard.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide which set out the terms of the residents' service and included the information required by the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

Improvements were required to the management of risk in the centre and to ensure that the risk management policy, as required by the regulations, was kept up to date and was subject to regular review.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had failed to ensure that there were suitable safeguards in place to mitigate the risk of an outbreak of an infections disease in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

Some fire safety equipment had not been serviced. In addition the records relating to fire drills needed improvement. The provider had failed to ensure that there were suitable drills being completed that simulated and emergency when there was minimal staffing.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider's system for the oversight, documentation and administration of medication needed review.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' personal plans required improvements. There was no evidence of any progress being recorded against the residents' goals in their personal plans. In addition, the personal plans had not been reviewed in light of COVID-19 to identify what goals may need to change or be adapted in order to meet the residents personal aspirations.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were being supported to access appropriate healthcare support. This included referrals to their GP or other allied healthcare professionals. In addition, there was evidence that residents were actively supported to access routine and acute care appointments as and when required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Behaviour support plans had not been subject to review by a behaviour support specialist. There was a reliance on a restrictive practice in one house on a routine basis and there was no evidence to show that this was the least restrictive measure that could be deployed.

Judgment: Substantially compliant

Regulation 8: Protection

Improvements to the systems, oversight and management of residents' finances, as identified by the provider, had not been fully implemented by the time of the inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Camphill Community Ballybay OSV-0003603

Inspection ID: MON-0030224

Date of inspection: 25/08/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: 1. PIC is currently continuing her Management Course which will conclude the last week in October. The Provider is in the process of identifying a Temporary Replacement PIC and will have returned information on this by 16th October.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The PIC has introduced a new rostering template, this template highlights staff assigned per shift, grade, and contracted hours. This template and system are now operational within Ballybay Community. 2. Special Project lead is currently undertaking a roster analysis to review the correct WTE and skill mix to ensure there is adequate professional staff to deliver a safe, effective and quality service. 3. Garda Vetting for all staff is now up to date, a new HR system will be introduced in CCoI by the end of 2020 which will increase the oversight and management of HR requirements	
Regulation 16: Training and staff	Not Compliant

development	

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. A full gap analysis of all staff training has taken place on 21/09/2020 Local Training gaps have been identified the local tracker has been updated. Required training has been booked and scheduled for staff. Comprehensive Induction Training is in place and records of this will be stored in each persons' file.

2. The PIC will conduct audits ensuring that all training and pending expired training dates are captured, ensuring all training is kept valid. Training requirements and upcoming training will be a standard meeting agenda item in the fortnightly Community Management Meetings to identify, schedule and review staff training requirements or new needs.

3. CCoI National training tracker is being created data is being collected and verified from each community currently, this data will then be imported into a national tracker, giving increased oversight around the management of training to the Operations and HR national teams.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The new standard CCoI management and governance processes have been introduced in the Ballybay Community through standard daily, weekly and fortnightly meeting systems each Community member with support needs requirements and preferences will be actioned and any new needs escalated to enhance their quality of life. The regional manager, regional safeguarding lead, and clinical support officer will attend a community management meeting monthly, where they can provide support, and constructive feedback around issues and concerns.

2. Regional Manager will attend Ballybay community fortnightly to check progress on action from Compliance plan and general spot checks.

3. PIC/ Quality & Safety Officer will complete weekly spot checks and walkarounds/audit where the PIC will select a theme and review the level of compliance for a residential house.

4. Review of supports provided to Community Members with support needs has been initiated. Critical case reviews will occur as required and resident's wellbeing reviewed ensuring meaningful day activities in place. Regional Clinical Support Officer will attend monthly Management meeting to offer support and oversight with any health issues or

behaviors of concern.

5. Regional safeguarding lead will attend monthly Management meeting to ensure comprehensive oversight and support.

6. 6 monthly inspection schedules will be in place to ensure that these are completed in a timely manner.

7. A review of operations and finance will take place to analyse the service needs and the resources required to operate the service by 30/11/2020

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:
1. CCoI have implemented new contracts of care, a process of discussion and engagement is currently taking place with Residents, families of residents and any responsible signatories. New contracts of care will be in place by 30th September 2020.

2. All current contributions are now in line with new Contract of Care.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
1. Updated and resubmitted to HIQA Inspector on 27/8/2020

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. Quarterly notifications Q1 & Q2 including NF39A submitted for April and July 2020 were both submitted in September 2020. Please note the Notification number for Q2 Not

- 0319879

2. All Current Restrictive Practice interventions are submitted and local Restrictive Practice Log up to date.

3. PIC has included the submission deadline for each quarter into calendar diary for the remainder of the year to ensure notifications are submitted within the designated timeframe.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
1. The CCoI Leadership Team commenced a process of updating overdue policies starting 13th July 2020

2. The revised contracts of care are in place since 01 September 2020

3. Revised residents finance policy is drafted, the associated SOP is being finalised and will provide a more robust money management assessment, daily and monthly reconciliation and sign off by PIC, with the records being maintained on an electronic system stored on SharePoint.

4. PIC/Quality and Safety Officer walkarounds and auditing of each house for compliance with e.g. infection and control measures to link policy and practice

5. As part of the organizational Performance Improvement Plan the Policies & Procedures will be reviewed and updated by 31st December.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
1. Money management assessments are up to date and there has been daily oversight of each person's finances by H/C and is signed off additionally by PIC since 23rd July 2020.

2. Following submission of NF06s with regard to nine Residents a Serious Incident Management Team Investigation has commenced.

3. A comprehensive review is being carried out by the PIC to analyse each Resident's access to their own bank account, engagement with families is ongoing.

4. All Residents contributions have been amended to reflect the correct amount stated on the new Contract of Care.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. A maintenance plan for tiling, painting and generally upgrading to one particular house is time-framed to be completed within a 6-month period, by March 2021.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. Business case has been developed to support an alternative living arrangements for one Resident in order to address and minimize risk posed to a peer due to incompatibility and to enable the elimination of current control measures which are restrictive for this Resident.

2. As part of the organizational Performance Improvement Plan the current Risk Management Framework is currently under review.

3. The update of this framework will ensure a clear risk identification and escalation pathway for all community risk.

4. A review of the community risk register is also underway and will be completed by 31st of October.

5. All new risks identified will be logged on the community register and will be reviewed monthly as part of the Community Management meeting.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. The PIC will schedule refresher training on Covid 19 protective measures for all staff. All staff will have completed Infection control training by 16/10/2020

2. An updated social story to include the high 5 gesture to support Residents on protective measures is being developed and will be in use by 9/10/2020.

3. Infection Prevention & Control will be a standard agenda item at all house and Community Management meetings effective as of 25/9/20. The implementation of SOP's on infection control measures and all updates and changes to practice required will be discussed to ensure all staff and volunteers are familiar with and understand the importance of following the SOPs.

4. PIC/Quality & Safety Lead walkarounds and auditing systems will include inspection on infection control. Outcomes from audits will include clear actions with timelines. First audit took place on 11/08/2020 and will continue monthly.

5. Soap dispenses and hand sanitizer dispensers were installed in all required bathroom and communal areas. Individual clip on hand sanitizer were issued to all staff and volunteers.

6. As part of the organizational Performance Improvement Plan the current Infection Prevention and Control Policy will be reviewed and updated by 31st December 2020

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Health & Safety Champion has been appointed since 31/08/2020. Champion will complete all scheduled fire drills throughout the Community and will be responsible for the completion of all necessary paperwork.

2. Out of hour fire drill will be planned biannually. The outstanding out of hours fire drill within the Community took place on 17/9/020

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 review of the operation of the organizations Medication Management policy within the community will be undertaken by the Clinical Support Officer by the 31st October 2020 with remedial action identified. The PIC & Clinical Support Officer will develop an implementation plan to address all areas requiring action.

2. Learning outcomes following all medication errors will be discussed with staff teams and the Clinical Support Officer at the monthly Community management Meeting to ensure effective risk management and learning. Minutes are circulated electronically.

3. All correct dosage of all PRN medication is now listed on all Residents medication Administration sheets. This was actioned on the day of inspection.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. All PCP's are in the process of being reviewed & updated with Residents and will be finalized at an Annual Review of each Resident. An annual review for each resident has been scheduled. All reviews will be completed by 27th of February 2021.
2. Goals have been reviewed and new Goals that can be achieved during Covid 19 reflective of each Residents personal aspirations are in the process of being developed. This will be completed by Residents with the support of Key worker by 30/11/2020

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. Clinical Support Officer is due to visit Community on 8/10/2020 to meet each House Co-Ordinator individually to schedule a full review of all positive Behavioral Support Plans. Reviews dates will be scheduled over the next 6 months to ensure all PBSP have been reviewed in that time frame. The schedule will be prioritised by complexity of presenting behaviors. This will be reviewed monthly with the Clinical Support Officer &

the management team at Community management meeting. Any changes in presenting behaviors for Residents in the preceding month will be discussed and plans adjusted, as necessary.

2. Compatibility issue of two Residents is being reviewed and alternative living arrangements is being explored. Business Plan has been developed to support new arrangements.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. All Residents contributions have been amended to reflect the correct amount stated on the new Contract of Care.

2. Oversight and management of Residents finances is double checked daily

3. Investigation is underway to analyse the overpayment of contributions and timeframe of same. Findings from this will be sent to HIQA when completed and the HSE Safeguarding and Protection Team.

4. Regional Safeguarding Lead will be attending monthly Management Meeting to offer support and to ensure effective oversight to the Community.

5. Formal Safeguarding Plans pertaining to the overpayment of contributions by Residents have been completed in consultation with CCOI Principal Social Worker and have been submitted to the HSE Safeguarding and Protection team.

6. Referral has been made for an Independent Advocate for all Residents for whom there has been an overpayment of contribution.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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.	Substantially Compliant	Yellow	01/12/2020
Regulation 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Red	16/10/2020
Regulation 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre,	Not Compliant	Red	16/10/2020

	the statement of purpose, and the number and needs of the residents.			
Regulation 14(3)(b)	A person who is appointed as person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have an appropriate qualification in health or social care management at an appropriate level.	Not Compliant	Red	16/10/2020
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	31/12/2020
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	21/09/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Not Compliant	Orange	30/11/2020

	appropriate training, including refresher training, as part of a continuous professional development programme.			
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	31/03/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/11/2020
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	31/12/2020
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	Not Compliant	Orange	30/11/2020

	details responsibilities for all areas of service provision.			
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	Red	02/10/2020
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	Red	02/10/2020
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the	Not Compliant	Red	18/09/2020

	resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/12/2020
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	Red	10/09/2020
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment,	Substantially Compliant	Yellow	26/09/2020

	means of escape, building fabric and building services.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	28/08/2020
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	28/08/2020
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	27/08/2020
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at	Not Compliant	Orange	11/09/2020

	the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Red	31/12/2020
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/11/2020
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident	Substantially Compliant	Yellow	30/11/2020

	is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/11/2020
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	31/10/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	11/09/2020