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:	The Bridge Community
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Short Notice Announced
Date of inspection:	07 August 2020
Centre ID:	OSV-0003605
Fieldwork ID:	MON-0028153

About the designated centre

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

The Bridge Community is located in a small town in Co. Kildare and provides residential, day and transitional training services to a wide range of people. There are five residential houses, three located within the main site and two houses located in housing estates in the community. The local town offers an array of amenities such as shops, a supermarket, bank, post office, public library, and community health services. There are various recreational and other facilities and workshops on the main site to provide work and learning experiences for the residents and day attendees. Residential services are provided to people with mild to moderate intellectual disabilities, physical and sensory disabilities and also those on the autism spectrum. The designated centre has capacity to provide full-time residential services for a maximum of 16 adults, male and female. Residents are supported by social care staff, care assistants and short-term co-workers (volunteers).

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
Friday 7 August 2020	10:30hrs to 18:30hrs	Jacqueline Joynt	Lead
Friday 7 August 2020	10:30hrs to 18:30hrs	Tanya Brady	Support

What residents told us and what inspectors observed

This centre is home to 14 residents and available as a respite service for one resident. The inspectors had the opportunity to meet with five residents on the day of inspection. While in the home, communication between inspectors and the residents took place from a two metre distance, wearing personal protective equipment (PPE) and was time limited in adherence with national guidance. A number of residents communicated with the inspectors independently, while other residents were supported by staff to talk with the inspectors. Where appropriate, residents' views were relayed through staff advocating on their behalf.

During the inspection, the inspectors observed residents engaging in different tasks including cleaning a bus, recycling and emptying bins. On a number of occasions residents came to the window of the room the inspectors were in and spoke briefly with them. The inspectors took a walk around the site, including the garden area, storage area and farm area and met briefly with residents. Overall, the residents appeared happy and content carrying out their tasks. Inspectors observed staff engaging with residents during this time and found this engagement to be friendly and mindful.

Later in the afternoon, the inspectors visited other residents in their homes. Each inspector visited a different house.

As per public health guidelines and advice, there were cohorting arrangements in place and residents were primarily based in their bedrooms throughout the day. The inspector spoke with two of the residents from the hallway outside their room at a two metre distance. The two residents were supported by staff to communicate with the inspector. The inspector observed that residents appeared relaxed in the company of staff. Staff acknowledged that the restrictions in place due to COVID-19 had posed challenges for the residents in relation to family visits. However, in the interim, residents had been supported to engage in online video calls with their families on a regular basis.

A resident explained that they liked their house, knew how to come and go and could request support from staff if required. They showed the inspector a jewellery box they had decorated and was seen discussing meal preparations for that evening with staff and relaxing in the living area. A different resident had just had a shower and explained to the inspector that their fresh t-shirt was of a band whose music they liked. They were happy to chat to the inspector and explained they really liked their home. Another resident greeted the inspector from inside their bedroom where they were resting in bed and stated they had been waiting to say hello. The inspector was able to greet them from the hallway.

Capacity and capability

This risk-based inspection was completed following receipt of information of concern submitted by the provider through a number of statutory notifications. The primary objectives of this inspection was to review the registered provider's oversight of the two outbreaks of infectious disease that had occurred in the designated centre and to follow up on their engagement with the appropriate services and the implementation of measures in relation to environmental health, public health and infection control. In addition, the inspection followed up on actions as set out by the provider in a compliance plan from a previous inspection in October 2019. Prior to this inspection, the provider was required to submit an update on the compliance plan actions and a copy of their unannounced review, which happens every six months, including the plan with actions and timelines. The person in charge was not available on the day of inspection. However, there were appropriate deputising systems in place and the quality and safety lead had stepped in as deputy. The deputy was found to demonstrate good knowledge of the needs of the residents and the supports required to meet those needs.

Overall, the inspectors found high levels of non-compliance across a number of regulations inspected against as part of this inspection. In addition, the inspectors found that a large number of actions outlined in the registered provider's compliance plan, which was submitted in response to the previous inspection of this centre, had not been implemented.

On the day of the inspection, the inspectors were provided with assurances that the provider had oversight of and had implemented the required measures in relation to environmental health and public health regarding the two separate infectious disease outbreaks. Despite this, an urgent action was issued to the registered provider after the inspection relating to infection control concerns. The inspectors received further assurances from the registered provider that additional action had been taken to address these issues.

The inspectors found that the governance and management systems in place did not always ensure that residents received a safe and quality service. There was evidence to demonstrate that the lines of accountability at individual, centre and organisational level were often unclear and that not all staff working in the centre were aware of their responsibilities or who they were accountable to. As a result, the initial oversight and management of the two infectious disease outbreaks resulted in unnecessary delays. For example, environmental health services and assurances that the required measures had been completed were delayed. Furthermore, through unsatisfactory communication methods between management and staff, there was a delay in the allocation of personal protective equipment (PPE) to one area of the centre.

The inspectors found that the oversight and monitoring of the centre at a provider level required improvement. The inspectors found that the systems in place in the designated centre to ensure that the service provided was safe and effectively

monitored was not always satisfactory. Audits were not carried out regularly and a number of audits were found to be not fully effective. For example, in 2020 there was no infection control audit completed prior to the 5 and 6 August 2020. In the second audit, it was noted that a number of the actions had progressed from the first audit. However, on the day of the inspection there were still actions outstanding. Furthermore, the audit did not identify persons responsible to complete the actions or time frames to complete them by.

Daily checks in each of the houses were stated as being carried out, which recorded the manager in place, the number of staff present and the tasks to be completed in the house including cleaning, finance and medicinal checks among others. However, the inspectors found from cross referencing with other documentation and checklists that a number of tasks marked as completed had not actually been completed. There were gaps evident on a large number of these records and in particular, the recording of the manager in place.

In early July 2020, the provider had organised for an external unannounced inspection to be completed for the designated centre. The purpose of this was to provide assurances that there was no immediate risk to the safety of any of the residents living in the centre and to identify areas for improvement.

The provider completed unannounced audits every six months, to monitor the safety and quality of care and support provided in the centre. However, while this was last completed in June 2020, it was over six months since the previous audit had taken place in May 2019. An annual report of the quality and safety of care and support in the designated had been completed for 2019. However, there was no evidence to demonstrate that an annual report had been completed in the previous two years.

The updated compliance plan submitted by the provider in advance of the inspection demonstrated that there had been a level of progress with staffing levels since the previous inspection in October 2019. However, a number of actions due to be completed by June 2020 had not yet been completed. The inspectors found that overall, the overarching systems relating to centre's workforce, and in particular the staff complement and staff training, required improvements to ensure full compliance with the regulations.

Inspectors reviewed a sample of staff personnel files and found they contained all information required by Schedule 2 of the regulations. Staff files reviewed demonstrated that not all staff were provided with inductions or probationary meetings. Furthermore, the inspectors found that staff one-to-one supervision was not taking place in line with the provider's policy.

The inspectors found that the registered provider had not ensured that the number, qualification and skill-mix of staff was in line with the centre's current statement of purpose. There were vacancies of 6.5 whole-time equivalent staff. The shifts affected by vacancies in regular staff were fulfilled by staff redeployed from other services, as well as staff provided through an agency.

The inspectors were advised that 10 short-term co-working staff living in mainland Europe had been offered positions. However, due to COVID-19 travel restrictions

they were unable up take up positions offered until September 2020. Overall, the inspectors found that due to the high dependency on agency staff, that continuity and care and support to residents could not be maintained at all times.

The rota in place for the designated centre included staff working in the centre and agency staff. In addition, there was a rota which demonstrated the different areas staff were allocated to throughout the day. However, inspectors found that the rota required improvements to ensure accurate identification of staff on duty. For example, staff surnames were not provided on the rota.

During visits to the houses the inspectors met with a small number of staff. The staff members displayed good knowledge of the residents' support needs, personalities, interests and communication support requirements. Inspectors observed friendly, casual, respectful and supportive interactions between staff and residents.

The inspectors found that staff were provided with up-to-date training specific to COVID-19, including how to prevent infection and minimise the risk of getting the disease as advised by the Health Service Executive (HSE) and Health Protection Surveillance Centre (HPSC). There was information for staff on updated HSE and HPSC guidance for residential care facilities. Staff were provided access to and availed of HSELanD and HPSC training material, online learning and educational videos in relation to infection prevention and control and the care of residents during the COVID-19 pandemic.

Overall, mandatory training was provided to staff in key areas such as safeguarding and manual handling. Due to the COVID-19 restrictions, the provider had put systems in place to support staff training through online sources such as safeguarding training and manual handling training. However, the inspectors found that a number of staff training required updating and a number of new staff had yet to receive their mandatory training. In some cases, dates had been provided for upcoming courses, however, this was not the case for all. For example, training in de-escalating techniques, medication management, on-site manual handling and on-site safeguarding training did not have dates.

The policies reviewed by inspectors were not consistently guiding staff practice. In addition, the registered provider had not reviewed all Schedule 5 policies within a time frame of no more than three years as required by the regulations. A number of the policies found not to have been reviewed included policies specific to health and safety and food safety and hygiene.

The inspectors reviewed contracts of care for residents and noted that they did not contain all information required by the regulations including charges and additional charges that the residents were responsible for in relation to their day to day support. In addition, some residents' charges had not been reviewed or updated since 2018. The provider had highlighted to inspectors that they planned to introduce a new contract for all residents (nationally across their service) which had been a feature of a number of recent inspections.

Regulation 15: Staffing

The centre's rota required improvements to ensure accurate identification of staff on duty. For example, staff surnames were not provided on the rota.

Overall, due to the high dependency on agency staff the continuity of care and support to residents could not be ensured at all times. The inspectors found that the registered provider had not ensured that the number, qualification and skill-mix of staff was in line with the centre's current statement of purpose.

Judgment: Not compliant

Regulation 16: Training and staff development

Overall, mandatory training was provided to staff in key areas, such as safeguarding and manual handling. However, the inspectors found that a number of staff training required updating and a number of new staff had yet to receive their mandatory training. In some cases, dates had been provided for upcoming courses; however, this was not the case for all. For example, training in de-escalating techniques, medical management, on-site manual handling and safeguarding did not have dates.

Staff files reviewed demonstrated that not all staff were provided with inductions or probationary meetings. Furthermore, the inspectors found that one-to-one supervision staff meetings were not taking place in line with the provider's policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, governance and oversight arrangements in the service failed to ensure that the systems and resources were in place to ensure a safe service and that all residents needs could be met at all times.

For example, the six-monthly unannounced review was not being carried out in line with regulations. The annual report had not being completed on yearly basis. Local audits lacked oversight and were found to be ineffective at times. The lines of accountability at individual, centre and organisational level was often unclear and not all staff working in the centre were aware of their responsibilities or who they were accountable to.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Residents' contracts were reviewed. These are important documents setting out the service to be provided to residents in addition to fees that may be charged. These were found to be inconsistently completed and did not contain all information as required by regulations.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider did not review policies and procedures in a timely manner and update them in accordance with best practice.

Judgment: Not compliant

Quality and safety

The designated centre consisted of two houses in the community and three houses on a campus setting, which included a large garden and small farm. The inspectors visited the farmland area of the centre and found that it provided a pleasant and inclusive environment for residents living there. There had been some progress to the overall care and support of residents since the last inspection; however, the inspectors found that a number of outstanding actions still remained. In addition, further improvements were required to ensure the safety and wellbeing of residents and in particular, relating to protection against infection, personal possessions and food and nutrition.

There had been two separate infectious disease outbreaks in the designated centre within a short period of each other. On the day of the inspection, the inspectors found that the provider had oversight of the outbreaks and had corresponded with the appropriate services and carried out measures required to ensure the safety of residents. However, improvements were warranted with regards to the overall systems in place to ensure that residents were protected against infection at all times.

A number of concerns were raised in relation to systems in place to prevent, detect and control the spread of infection and post inspection the provider was required to

submit an urgent action plan providing assurances that concerns had been appropriately addressed. Satisfactory assurances were subsequently submitted by the registered provider which outlined measures undertaken to ensure residents would be protected from acquiring healthcare associated infection.

For the most part, there was a satisfactory contingency plan in place for residents should they need to self-isolate in the centre. In one of the houses, where there were cohorting arrangements in place, the inspector saw that appropriate personal protective equipment (PPE) stations had been set up outside each of the residents' bedrooms. However, in one of the houses, the plans required reviewing to ensure that all residents were provided with appropriate bathroom facilities should they be required to self-isolate.

There was up-to-date guidance and information available to staff and residents in relation to infection prevention and control. The inspectors found that staff had been provided with training in donning and doffing (putting on and taking off) PPE, and since the outbreaks had occurred in the centre had received further refresher training on the organisation's standard operating procedures for infection control. However, on the day of inspection, there were times throughout the day that staff were observed not wearing PPE in line with current guidance. An infection control audit had taken place in the centre on 5 and 6 August 2020 and a number of actions had been identified. However, there were no persons or timelines identified assigned to the actions to be completed. There were cleaning schedules and checklists in place in each of the houses. Staff were provided with a checklist which included areas to be cleaned, both in the morning and again in the evening. However, on review of the checklists the inspectors found that they did not always demonstrate that cleaning had been completed, or by whom.

Adequate supplies of hand sanitiser and hand soap were observed in appropriate areas of the centre, along with signage reminding staff, residents and visitors of hand hygiene practices. Staff training records indicated that staff were provided with training in hand hygiene and correct usage of personal protective equipment.

Inspectors also saw evidence of good systems in place to educate and inform residents about how to stay safe during the ongoing pandemic. A variety of easy-to-read information and social stories were available for residents, for example to clearly explain and provide reassurances around the testing procedure. There was evidence to demonstrate that staff had reviewed this information with the residents to ensure their understanding of it.

Overall, appropriate healthcare was available to residents having regard to their personal plan; however, the inspectors found that plans had not being reviewed on a quarterly basis as per the centre's statement of purpose. Overall, the health and wellbeing of each resident was promoted and supported in a variety of ways including through diet, nutrition, recreation, exercise and physical activities. Residents were supported to live healthily and, where appropriate, take responsibility for their health. From a sample of residents' personal plans, the inspectors found that each resident had access to health and social care professionals, including access to a general practitioner (GP) of their choice. Where

appropriate, residents were supported to avail of multidisciplinary supports such as physiotherapy, occupational therapy and speech and language therapy. The inspector saw that there were delays in some of the residents' clinical referrals. However, the inspectors were advised that current restrictions in place had posed challenges in organising some appointments. Residents were provided with a hospital passport to support them if they needed to receive care or undergo acute inpatient treatment.

In general, inspectors found that residents were provided with wholesome and nutritious meals and were appropriately supported at mealtimes in line with their assessed needs. The inspectors saw that some of the residents' plans referred to specific types of diets, however, there had been no clinical oversight in recommending these diets. Residents had choice and control with meals, refreshments and snacks, although as stated, some were limited for specific dietary requirements. Storage facilities for food items that had been contained in a centralised location were noted to be visibly unclean and there had been no temperature checks or cleaning schedules in place to ensure food had been stored in hygienic conditions. While the storage facility for meat and eggs was closed on the day of inspection, the refrigerated store for milk and other items was still in use and the inspectors were not provided with evidence that temperature checks or cleaning schedules were in place for this. Within the houses, the inspectors noted that temperature checks for the fridges had only begun in the preceding days. When food was opened and placed in the fridge no record of opening dates was kept.

Where required, residents had positive behaviour support plans in place. Inspectors reviewed a sample of these plans, however, they were undated and so it was not possible to ascertain if they contained appropriate current guidance. A summary of the key points of residents behaviour support plans was in place for some residents and these were seen to be dated in 2017. There was evidence that behaviours that challenge were reviewed and included in residents' personal plans. The inspectors found that there were a number of restrictive practices in place in the centre. However, the system in place to record these or formally review to ensure they were used in the least restrictive manner for the shortest period of time were found to be inadequate. Where there were systems in place such as sensor mats on beds the service records for these were not maintained in the centre.

The inspector found that the fire fighting equipment and fire alarm systems were appropriately serviced and checked and that there were satisfactory systems in place for the prevention and detection of fire. Following the inspection, the quality and safety lead followed up with further documental evidence demonstrating that the fire precautions equipment and alarms in the centre had been serviced by an external company in June 2020. The inspectors reviewed a sample folder from one of the houses and found that fire drills were taking place at suitable intervals. However, inspectors found that the documentation of the drills required review to ensure sufficient information was recorded. Residents were provided with personal evacuation and escape plans and they were found to be reviewed in January 2020.

The provider's audit, carried out every six months, had identified a concern relating to the evacuation time for one resident during a fire drill. This had been risk

assessed and the resident's personal evacuation plan had been updated. The quality and safety lead advised that the resident could evacuate safely. However, to better meet the residents assessed needs plans were in place to transition the resident to a ground floor room in the house. For the most part, staff had received suitable training in fire prevention and emergency procedures, building layout and escape routes, and arrangements were in place for ensuring residents were aware of the procedure to follow. However, on the day of inspection the inspectors found that a number of new staff required fire safety training and a number of current staff required refresher fire safety training.

The provider had a risk register present within the centre for overall risks. A separate document had been developed for each house within the centre to take into account the varying hazards and level of risk identified. Development of the risk register had been identified on previous inspections and the actions identified by the provider were still not fully completed. A risk had been identified following the outbreak of infectious disease and, although incident review had been completed, this had not been addressed within individualised and or centre risk registers. All incidents in the centre were documented by staff members present at the time. However, some incidents had not been documented as reviewed by the person in charge or management team as per the provider's policy. In addition, while incidents were available for inspectors to review there was no evidence available of auditing or learning from these.

Staff spoken with were knowledgeable regarding processes in place for the management of residents' finances. Systems were in place for the recording of daily expenditure; however, these were not always signed and dated by a minimum of two senior staff members as per policy. Residents' personal finances were stored in secure facilities, and following a check on a sample of residents' finances, inspectors found that records on the day accurately reflected sums of money in place for individuals. It was observed, however, that daily checks of balances were not consistently carried out with one resident having five days in a month where their wallet balance was not checked as required. For another resident, there were two amounts recorded on one day and no reason given for the variation between the amounts nor a corresponding receipt.

Family members were supporting some residents to manage their finances. At times, this posed difficulties and potential risks. Residents did not have full access to their own money at all times and some had no bank card or sight of their accounts. Staff and management supporting the residents did not have oversight of the residents' spending, for example they had no copies of bank statements and therefore could not complete audits in line with the service policy. However, inspectors acknowledged that referrals for residents to be supported by independent advocates had been made within the last month and in addition there was evidence of open engagement with families of residents.

All staff had received training in the safeguarding and protection of vulnerable adults. Where required, residents had formal safeguarding plans in place, these were under review as per the timelines set, however, not all were closed in a timely manner. The inspectors noted that for some residents interim plans remained in

place, in one case since November 2019; however, this had been reviewed the week before the inspection and was still open. Where residents required support with intimate care there were plans in place to guide staff, however, a number of these were seen to be more than a year in place and were not reviewed as required by the provider, with one plan not being reviewed in 18 months. Inspectors also noted undated safeguarding guidance in residents' files for staff to follow and there was no evidence to demonstrate that processes in place for review or if the guidance was still required.

Regulation 12: Personal possessions

Staff and management supporting residents who did not have access to their own finances did not have consistent oversight of the residents' spending. At times they had no copies of bank statements, and therefore could not complete audits in line with the service policy. Daily checks were not completed as required.

Judgment: Not compliant

Regulation 18: Food and nutrition

Inspectors found that residents were provided with nutritious meals, however, some of the residents plans referred to specific types of diets and there had been no clinical oversight in recommending these diets.

Inspectors noted that food was being stored in conditions where regular temperature checks and cleaning schedules were not in place. Some food storage facilities were observed to be visibly unclean. Additionally there were no systems in place to ensure monitoring of dates when food was opened and therefore remained within a 'best before' condition on consuming.

Judgment: Not compliant

Regulation 26: Risk management procedures

Risks relating to infectious disease required updating. There were risk registers in place per each house and for the centre overall. The risk management policy and the health and safety policy had not been reviewed as per the updated compliance plan and the centre level risk frameworks were also still as per the updated compliance plan.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Overall, the systems in place to protect residents against infection were unsatisfactory and were not always in line with current health guidance or with the National Standards for infection prevention and control in community services published by HIQA.

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurances that the risk was adequately addressed.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspector found that the fire fighting equipment and fire alarm systems were appropriately serviced and checked and that there were satisfactory systems in place for the prevention and detection of fire.

For the most part, staff had received suitable training in fire prevention and emergency procedures, building layout and escape routes, and arrangements were in place for ensuring residents were aware of the procedure to follow. However, on the day of inspection the inspectors found that a number of new staff required fire safety training and a number of current staff required refresher fire safety training.

Judgment: Substantially compliant

Regulation 6: Health care

Overall, the health and wellbeing of each resident was promoted and supported in a variety of ways including through diet, nutrition, recreation, exercise and physical activities. For the most part, appropriate healthcare was made available to residents having regard to their personal plan however, the inspectors found that plans had not being reviewed on a quarterly basis as per the centre's statement of purpose.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Positive behavioural support guidelines required review to ensure that the guidelines were current.

There was use of restrictive practice in the centre and the inspectors found that improvements were required in relation to documentation of these practices.

Judgment: Not compliant

Regulation 8: Protection

While improvements in the systems of recording and reporting were apparent over the last year, further improvements were warranted to ensure records were reviewed and updated within appropriate timelines.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for The Bridge Community OSV-0003605

Inspection ID: MON-0028153

Date of inspection: 07/08/2020

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. All staff surnames are on the house specific rosters with colour coding in place to identify core social care workers, relief staff and agency staff. This has been put in place as of 10/08/20. 2. The Person in Charge will ensure continuity of care for all residents through twice monthly welfare meetings with house coordinators which will review all residents' needs. The next meeting is scheduled for 15/09/2020 3. A HSE led roster review was completed by the Person in Charge on 08/09/20 which highlighted the support needs of the residents. This information has been returned to the HSE and advice is to follow. 4. A recruitment drive is currently ongoing with the aim to achieve full compliment of staffing as per statement of purpose by 18/12/2020.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. A full gap analysis of all staff training has taken place on 09/09/20. 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. Advice has been provided by the clinical team to roll out Studio 3 de-escalation training and refresher training for those who have already completed it. This roll out of de-escalation training will be completed by 31/10/20.

3. Schedule of Supervision for frontline staff in place and operational from 14/09/2020. PIC will oversee this monthly with House Coordinators. CCoI rolling out new standard support and supervision system, using national templates incorporating governance and management. Schedule for PIC support and supervision for House Co-Ordinator in place to end of year. Completed 30/9/2020.

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

5. 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. New CCoI operations management and governance structure is being rolled out at the Bridge commencing on 10/9/20 and an implementation plan will be developed for the Bridge. This involves a systematic approach to operating and managing services 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. Regular audits, which involves documented checking of all documentation regarding schedule 2 (staffing), training, risk management, residents finances, residents files, clinical support and records.

3. The PIC has access to electronic tracking data on risk – specifically for Safeguarding, Behaviors of Concern, Accidents and Incidents and Medication errors ensuring that areas can be raised quickly.

4. A community SharePoint site is in place for the Bridge creating the infrastructure for increased oversight. where all records are stored, increasing the level of oversight for the PIC at house level, and above.

5. There will be a national schedule to ensure that Reg 23 Unannounced Inspections are be completed 6 monthly in all Communities, a schedule of these audits will be developed and submitted to Head of Service by 30/09/2020.

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

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 will be implementing new contracts of care, a process of discussion and engagement is taking place with Residents. Families of residents and any responsible signatories will be contacted during this process. New contracts of care will be in place in September 2020.

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 on week starting 13th July 2020. A part time policy developer has been employed at national level.

2. The revised contract of care will be in place by September 2020.

3. Revised residents finance policy is complete, the associated SOP is being finalized 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. The Bridge will pilot this new SOP from 30/10/2020.

4. Review of money management assessments by PIC, ensuring that supports provided

to residents are in line with their assessed needs and consent for support is documented.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
1. Revised residents finance policy is complete, the associated SOP is being finalized 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. The Bridge will pilot this new SOP by 30/10/2020.

2. The PIC will instruct and spot check that all residents have a money management assessment and review inventory list of personal possessions be reported accordingly, these measure will be in place by the 30/10/2020.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
1. The PIC has instructed that all stored food items that are refrigerated have twice daily refrigeration temperature checks recorded. This system is monitored weekly by house coordinator and audited monthly by the PIC. This is in place as of 06/08/2020

2. All food stocks are dated and stock rotated. The opening dates of all sealed food items is noted using day/date stickers. This system is monitored weekly by house coordinator and audited monthly by the PIC. This is in place as of 17/08/2020

3. Referrals are being sent to the GP to review any food intolerances or specific diets. This has commenced on 3/9/2020.

4. The PIC has spot checked all of these measures and note their initial implementation as of the 06/08/2020.

Regulation 26: Risk management	Substantially Compliant

procedures	

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The National Health and Safety officer has reviewed the draft risk management policy to incorporate reg. 26, this has been forwarded to and approved by HSE.

2. The National Risk Management framework will be shared by the National Health and Safety Officer with and reviewed by HSE on 07/10/2019 HSE. This framework will outline the process of risk identification through risk analysis, evaluation, action planning, implementation and review of controls.

3. Review of the local risk register will be conducted by National Health and Safety Officer and PIC 09/10/2020.

4. A Risk Assessment of Healthcare Workers with Potential Workplace Exposure to Covid19 Case (v3.0) has been in place since 01/03/2020.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. CCoI National Clinical Lead had developed SOP's in relation to mask wearing in the centre, all staff members had received training prior to inspection. The PIC will schedule refresher training in the wearing of masks within the centre, this training will be completed by all staff by 30/09/2020.

2. All SOP's will be discussed on a regular basis to ensure all staff /volunteers are familiar and understand the importance of following the SOP.

3. PIC/Quality and 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.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Training schedule to include fire safety training and refresher training for all staff. All

staff will have completed theirs in full by 25/09/2020 and refresher training on fire safety by 20/11/2020

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. There is a 12 week review and implementation plan of all care plans in place which began on 04/09/20 and will be completed by 20/11/2020.

2. This will be part of the roll out of the new implementation plan on each persons file. A schedule of quarterly reviews and an annual review of each residents support needs which will include a review of the personal plan.

3. The operational management process being introduced to five pilot sites including this centre will have two centre management meetings per month. One of these meetings will have the attendance of the regional clinical support officer, and regional safeguarding officer in attendance. Health care issues for residents will be a key focus of this inter disciplinary community management meeting where cases will be reviewed, new cases discussed, actions plans and interventions agreed. Should a case be more complex or urgent it will be escalated to the critical case review process with senior clinical lead. Equally should urgent cases emerge between monthly inter disciplinary meetings they will be escalated to the critical case review process. The next community management meeting is scheduled for 22/10/2020.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. An 8 week review and implementation plan of behaviour support plans has been started on 07/09/2020 and will be completed by 30/10/2020.

2. All restrictive practices have been reviewed as of 07/09/2020 and scheduled for review as part of quarterly and annual reviews of care plans.

3. Advice has been provided by the clinical team to roll out Studio 3 de-escalation training and refresher training for those who have already completed it. This roll out of de-escalation training will be completed by 31/10/20.

4. Current and emerging behavioural support issues will be an agenda item under clinical agenda at the new centre operational management process. This process being introduced to five pilot sites including this centre in September 2020. The regional clinical support officer, and regional safeguarding officer will be in attendance and behavioural support needs of individuals will be review as needed in this forum. Revision of existing BSPs / new actions arising / new cases will be discussed, actions agreed, documented in the individual BSP / BSP commenced as appropriate and communicated to teams for implementation . Should a case be more complex or urgent it will be escalated to the critical case review process with senior clinical lead. Equally should urgent cases emerge between monthly inter disciplinary meetings they will be escalated to the critical case review process. The presence of both the regional clinical and safeguarding lead along with the regional ops manager with PIC and House Coords is central and deliberative to this process. The next community management meeting is scheduled for 22/10/2020.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. Safeguarding tracker provides contemporary oversight and highlights due dates for review on all interim and FSP's. DO will complete a review of all plans in conjunction with the Regional Safeguarding Lead by 20/10/2020

2. A review of all intimate care plans will be concluded by 20/11/2020 in line with the new file architecture as part of 12 week review and implementation plan.

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.	Not Compliant	Orange	30/10/2020
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	Red	18/12/2020
Regulation 15(3)	The registered provider shall	Not Compliant	Orange	15/09/2020

	ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	10/08/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/10/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/10/2020
Regulation 18(1)(b)	The person in charge shall, so far as reasonable and practicable, ensure that there is adequate provision for residents to store food in hygienic conditions.	Not Compliant	Orange	17/08/2020
Regulation 18(2)(d)	The person in charge shall	Substantially Compliant	Yellow	03/09/2020

	ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.			
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	Red	25/09/2020
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 details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	30/09/2020
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'	Not Compliant	Red	30/09/2020

	needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	30/09/2020
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	Orange	30/09/2020
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the	Not Compliant	Orange	30/09/2020

	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.	Substantially Compliant	Yellow	09/10/2020
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	21/08/2020
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures,	Substantially Compliant	Yellow	20/11/2020

	building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
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	Orange	14/09/2020
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	20/11/2020
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/10/2020
Regulation 07(4)	The registered provider shall	Not Compliant	Orange	07/09/2020

	ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	20/11/2020