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:	Announced
Date of inspection:	09 October 2019
Centre ID:	OSV-0003605
Fieldwork ID:	MON-0022536

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:	15

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
09 October 2019	09:30hrs to 19:00hrs	Erin Clarke	Lead
09 October 2019	09:30hrs to 19:00hrs	Valerie Power	Support

What residents told us and what inspectors observed

A strong community ethos was evident in the centre. The inspectors of social service observed residents engaging together in activities that contributed to the running of the centre, according to their abilities. Friendly, respectful interactions between staff, volunteers and residents were seen throughout the day. It was evident that staff knew the residents and their preferences; for example, one staff member showed an inspector how they had learned a selection of relevant signs in order to better connect with a resident who used non-verbal communication.

The inspectors met and spoke with two residents who lived in a house which was part of the designated centre, but were supported to live more independently in the community. These residents were seen to choose their daily activities in line with their personal preferences and goals. One resident had independently visited another house in the centre on the morning of the inspection, and was observed to be content and engaged in activities with peers there. The other resident came to visit the inspectors while running errands in the community. They told the inspectors about their plans for the day, their recent holiday abroad, and how they were supported in their home according to their needs. They also spoke about how they felt comfortable making suggestions or complaints and felt their views were listened to and acted on in a timely manner by the provider.

Inspectors also reviewed results of a survey carried out by the registered provider, which had been completed by seven relatives or representatives of residents. Responses were positive about the overall quality of care and support provided in the centre, particularly in the areas of assessments and care planning, health and well being, home life, social and work life. Respondents cited some concerns about a lack of consistent, familiar staff in the centre at times. Respondents also expressed a desire for improved communication from the registered provider regarding changes in the centre.

Questionnaires from the Office of the Chief Inspector had been posted to the centre before the inspection to gain the views of residents about the service provided to them. The inspectors had received six completed questionnaires. Three of these were completed by residents themselves and three with the support of a staff member. All residents replied that they liked living in the centre and that they were happy with how comfortable and warm their homes were. Other areas of high satisfaction were the space residents had for their personal belongings, their bedrooms and meals provided. Residents also liked spending time with staff. One area some residents stated that they would like improved was access to increased activities outside of the centre such as horse riding, education and trips to the cinema.

Capacity and capability

The inspectors found that the designated centre was not sufficiently resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. The provider's capacity and capability to support residents was negatively affected by funding restraints. This resulted in difficulties to recruit and retain staff resulting in a high turnover of staff and deficits in local governance arrangements. Furthermore, improvements were required in the centres own monitoring systems and the completion of actions from previous inspections. Even though the provider had significant improvements to make, the inspectors identified areas of good practice in relation to the management of complaints, supervision of staff and the review of adverse incidents in the centre.

The provider had submitted a complete application to renew the registration of this centre. As part of the announced renewal of registration inspection, the inspectors inspected against 19 regulations; eight of the regulations were found to be compliant, five substantially compliant and six regulations were not compliant with the regulations.

As identified in previous inspections the centre was operating below its full staff complement of six whole-time posts. Also, there had been additional reductions in core staff since the last inspection of June 2019. From a review of rosters over two months, inspectors found that 19 staff were used from a relief and agency panel in order to cover these shifts to meet residents meets. This did not ensure an adequate continuity of care to residents. The impact of which was identified in residents questionnaires and observations made by inspectors during the inspection. It was unclear from the rosters who was assigned to work that day and where the staff member was located. A large spreadsheet was used to maintain the actual and planned roster for all houses and additional planners were used to signpost where staff where located. This required review to ensure all required information was contained within each locations roster.

The inspectors found that local governance arrangements were not effective in reviewing and monitoring of all key areas. A house coordinator post was unfilled for a period of two years. While this had been rectified at the previous inspection, the post had since become vacant again. As a result, the person in charge was not fully supported in ensuring a consistent approach of the oversight of service provision. The inspectors were informed that a new person had been appointed to this role and would commence in the coming weeks.

There was a lack of sufficient monitoring and auditing in place to assess progress and identify areas for improvement. While the person in charge had commenced a self-auditing tool based on the National Standards for Residential Services for Children and Adults with Disabilities 2013, it had not resulted in scheduled management audits on all aspects of the centre's operations. The provider had not ensured that day-to-day internal checks were carried out by staff as observed by inspectors. It was also identified that the provider was not complying with the

requirement of the regulations to conduct an unannounced visit and subsequent report of the centre every six months, the last one being completed in February 2019. Also, an action from the previous inspection in relation to outstanding annual reviews had not been completed as stated in the compliance plan. The inspectors acknowledged that the consultation process had commenced with residents as part of this review but an annual review of the quality and safety for 2018 remained outstanding.

Staff in the centre had access to training as part of their continuous professional development. The person in charge maintained a staff training log and training plan. All staff and volunteers had up-to-date safeguarding training. However, several staff required training or refresher training in areas that are essential to ensure the safety of residents and staff alike, including fire safety, moving and handling of people, managing behaviour that is challenging (Studio III), safe administration of medicines, and manual handling. In addition, the training requirements for certain staff roles were unclear. The staff training plan outlined a prioritised approach to addressing training needs; for example, all staff requiring fire safety training were scheduled to complete it by the end of the month, and all staff requiring Studio III training were scheduled to complete it by the end of the year.

Staff and volunteers in the centre had formal supervision meetings with management. Sample supervision meeting records seen by inspectors indicated that supervision was regular, encouraged open discussion and prompted clear actions that were of benefit to practice.

The required written policies and procedures were in place in the centre; however, a number of these documents had not been reviewed within the past three years. The registered provider informed the inspectors that arrangements were in progress to review and update all policies and procedures, but this work had not yet been completed on the day of inspection.

The person in charge maintained records of all adverse incidents that took place in the designated centre, involving residents, day attendees, staff and volunteer co-workers. Records clearly indicated which incidents were to be notified to the Chief Inspector, and these incidents were found to have been notified appropriately.

The registered provider had an effective procedure in place to address and resolve complaints raised by residents or their representatives, including an appeals process. Information on the complaints procedure was displayed in the centre. Complaints were documented using a clear and accessible form. The inspectors saw that records of complaints were maintained, which indicated that most complaints were dealt with at a local level, in a timely manner, and complainants were satisfied with the actions taken. There was one open complaint on the day of the inspection, and lengthy discussions took place regarding the steps taken to date and the efforts made to resolve the compliant to the complainant's satisfaction.

The statement of purpose is a key governance document which sets out how the centre is to run and what residents and staff can expect to see in the service. It is required to be kept up to date and under regular review. This document required

some review to detail the precise number of residents to be accommodated in the designated centre; a reflective governance structure and accurate staffing and management arrangements.

There were written agreements for the provision of service in place in the centre. These agreements included the required information and had been agreed with most residents or their representatives. However, review was required to ensure that a schedule of fees charged to residents was included in all contracts.

Regulation 14: Persons in charge

The person in charge was suitably qualified, dedicated to this centre and had good oversight of the residents care needs and supervision of staff.

Judgment: Compliant

Regulation 15: Staffing

Additional staffing arrangements were subject to funding and were not yet in place or approved at the time of inspection. An over reliance on the use of relief staff had resulted in a lack of continuity for residents. Rosters required review to ensure that they accurately reflected all staff that were working in the designated centre and which house they were assigned to.

Judgment: Not compliant

Regulation 16: Training and staff development

A number of staff required training or refresher training in areas that are essential to providing quality care and support for residents. A prioritised staff training plan was in place to address training needs, but required review to ensure it was clear and consistent across all staff roles.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had valid insurance cover in place for the centre, in line with

the requirements of the regulation.

Judgment: Compliant

Regulation 23: Governance and management

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.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

A sample of contracts for the provision of services were reviewed and it was noted that not all contracts set out the fees to be charged. The inspectors also noted a discrepancy in the number of weeks the service was operational for.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose did not contain all information required under Schedule 1 of the regulations.

Judgment: Not compliant

Regulation 30: Volunteers

All volunteers had their roles and responsibilities set out in writing and supervision arrangements in place.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge maintained records of incidents in the designated centre and ensured that relevant incidents had been notified to the Chief Inspector within the required time frame.

Judgment: Compliant

Regulation 34: Complaints procedure

An accessible and effective complaints procedure was in place in the centre, in line with the requirements of the regulation. Up-to-date records of complaints, associated actions and the satisfaction of complainants were maintained.

Judgment: Compliant

Regulation 4: Written policies and procedures

While the prescribed Schedule 5 written policies and procedures were in place, many had not been reviewed or updated at the required intervals.

Judgment: Not compliant

Quality and safety

The provider was making active efforts to ensure that the needs of all residents were met and was listening to and acting on the concerns raised by residents. Residents were treated in a respectful and caring manner while living in the centre. However, quality and safety in the long term in this centre was linked to staffing levels and resourcing of the centre which were found to require improvement still. It was identified that the provider was managing risk and safeguarding concerns well with a good knowledge of the local risks in the centre. Improvement was required in relation to medicines management, review of restrictive practices and completion of health plan actions.

Inspectors reviewed a sample of residents' care plans and found that they were comprehensive; clearly guided care and support practices, and were based on up-to-date assessments of residents' needs. The person in charge ensured that all aspects of the residents' needs were captured including, personal growth, being part of a community, lifelong learning, making decisions and physical well being. A new template had been implemented to streamline information and staff spoken with

clearly demonstrated knowledge of these needs. It was also identified that residents and their representatives, where appropriate, were consulted in the review and development of care plans.

Sample personal plans viewed by inspectors were person-centred, were developed in consultation with residents and their representatives, and were specific to the resident's personal development goals. Annual reviews were used to review the effectiveness of the resident's personal plan to meet their needs and identify personal social and developmental goals for the next 12 months.

The inspector found that the premises were well equipped to meet the needs of the residents with ample and suitable communal and private accommodation ready and available. The provider spoke to the inspectors regarding a future plan to decongregate one larger building on the campus with the construction of a smaller purpose-built building also on site.

The availability of vehicles and trained staff to provide transport were integral to facilitating residents' participation in the community, particularly at weekends, when public transport was infrequent. There were five vehicles available in the centre to transport residents, and eighteen licensed and trained drivers. The registered provider had systems in place to ensure that vehicles were roadworthy, insured, and that an adequate number of staff were trained to carry out vehicle safety checks.

Inspectors saw evidence that residents were supported to access health care according to their needs. Residents were supported to access medical and allied health practitioners as required and to participate in relevant national screening programmes. In cases where a resident refused medical assessment, this was clearly documented. Specific supports required by residents to facilitate medical assessment or treatment were also documented. Inspectors found some lack of consistency in following up on allied health advice, specifically in relation to monitoring residents' weight and dietary intake. Inspectors were told by staff that residents may refuse weight checks on occasion, but no such refusal had been documented in care plans

Residents had detailed positive behaviour support plans in place, where required, which had been informed by appropriate assessments. The use of restrictive practices was minimal; however, improvements were required in the recognition of the use of restrictive practices and to ensure they were applied in accordance with national policy and evidence-based practice. As previously mentioned, not all staff had yet completed trained in managing behaviour that is challenging.

Residents were found to be well protected in the centre with clear guidelines and protocols in terms of the safeguarding of all residents, staff and visitors in place. A recent safeguarding matter was under review, and the inspector found an appropriate provider response and safeguarding plan in place. Residents communicated that they felt safe while availing of the services of the centre. The inspectors were assured that there were appropriate systems in place for managing and responding to incidents of a safeguarding nature should they occur in the centre.

The registered provider had a risk management policy and framework in place to guide staff practice concerning risk throughout the organisation. The risk management policy was currently under review to ensure that it included all elements required by the regulation. The local risk register for the centre was comprehensive and reviewed regularly. Individual risk assessments were included in residents' care plans were appropriate; for example, where a resident was awaiting assessment by an allied health professional, an interim risk assessment and control measures were in place.

The practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines were found to be inadequate. They not protect residents from potential medication errors or support safe and consistent practice. While reviewing one resident's personal plan it was noted that guidance was not available in relation to the administration of PRN medicine (medicine only taken as the need arises). This resulted in ambiguity in the administration of two types of pain relief medicine. There was also a discrepancy in the dose administrated and the actual and recorded stock check. The inspectors also found out of date topical medicines and the presence of over the counter medicines that had not been prescribed. Medicine audits had not occurred to ensure that corrective action was put in place to address any errors.

Inspectors found suitable fire precautions were in place in the centre. In the houses visited by the inspectors, clear procedures in case of fire were displayed prominently. There were adequate escape routes for individuals with and without mobility impairments, which were clearly highlighted by signage and emergency lighting. Staff and volunteers spoken to showed good awareness of fire procedures. Fire doors and appropriate fire fighting equipment were in place throughout the houses visited. Appropriate fire alarm systems were in place, and records indicated that they were regularly checked by staff and serviced by an external company, as required. Inspectors viewed sample personal emergency evacuation plans and found that they clearly guided staff practice and had been reviewed regularly. Fire drills had been carried out in the centre to ensure residents could be effectively evacuated. It was unclear from the records of fire drills if they reflected all potential fire scenarios. For example, simulated night-time fire drills were not recorded. Information received post-inspection clarified the documentation issues. Some staff required refresher fire training which was scheduled to take place within the month, as stated in the staff training plan.

Regulation 17: Premises

The design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs. The centre was clean, comfortably furnished and well decorated.

Judgment: Compliant

Regulation 26: Risk management procedures

A centre wide risk register was in place along with risk assessments relating to individual residents. Such risk assessments were noted to have been recently reviewed while staff present in the centre demonstrated a good understanding of any risks present in the centre. The risk management policy required review to ensure it included all required elements as outlined in the regulations.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had ensured that fire safety management systems in the centre were effective. Some staff required refresher training in fire safety, and were due to complete it in the month following the inspection.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

It was found that the practices and protocols in place for the ordering, receipt, prescribing, storing, disposal and administration of medicines were not adequate.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan that detailed their needs and outlined the supports required to maximise their personal development and quality of life in accordance to their wishes.

Judgment: Compliant

Regulation 6: Health care

The health care needs of residents were set out in their personal plans and adequate support was provided to residents to experience the best possible health. Appointments with allied health professional were facilitated with records maintained of these. The health of residents was regularly monitored although it was noted that the consistency of weight monitoring for some residents required improvement.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where residents presented with behaviour that challenges, the provider had arrangements in place to ensure these residents were supported and received regular review. Improvements were required in the recognition of the use of restrictive practices and to ensure they were applied in accordance with national policy and evidence-based practice.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors observed that there were systems and measures in operation in the centre to protect the residents from possible abuse.
Staff were facilitated with training in the safeguarding of vulnerable persons.

Judgment: 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	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Bridge Community OSV-0003605

Inspection ID: MON-0022536

Date of inspection: 09/10/2019

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:
There are ongoing recruitment drives to ensure safe and effective services are provided and meet the assessed needs of the residents of the community. Any gaps in staffing are currently being filled by core social care team, relief panel and agency social care staff.

Recent measures have been approved at National level as of 01/08/2019 to improve attraction and retention of qualified and experienced staff to the Bridge community by increasing rate of pay to competitive levels with other local Camphill communities. Organizational plans and associated funding discussions are progressing with HSE at national lead level.

A National Lead - HR has been appointed and commenced in post as of 08/11/2019. A key function of this role will be the securing of a staff team with the skill mix against the assessed needs of residents for each CCoI community. Other associated actions are the centralisation of payroll to a national function from 1/1/2020. The introduction in 2020 of a HR IT system. These systems will give greater information oversight from time of advertisement to recruitment and trough career path for employees. This will enhance support and information systems for staff. Full roll out of HR management system 31/06/2020.

Since last recruitment drive which ended, the community has successfully recruited 1 Social Care worker, 1 Social Care assistant and 1 Day Service facilitator. This improvement on the skill mix will be built upon.

The current recruitment drive is advertising for Social care workers x 1, social care assistants x 3. The latest recruitment drive takes place from 11/11/2109 with applicants being invited to interview by 13/12/2019.

The roster is currently being reviewed by the Person in Charge and will be updated clearly showing staff on duty during the day and night. This will be reviewed and the

updated roster system will be in place on 06/01/2020.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The prioritized training plan is currently under review. The new version of the training plan will highlight when training is due rather than highlighting when training was completed, this will eliminate overdue training.
Each staff member will also have a detailed training plan that will specify the training required for their specific role. This training plan will be in place by 20/12/2019.

The national HR lead role commenced 8/11/2019, this role is being supported by the development of a HR department equipped with an HR IT system. This system will be accessible to the national HR team and the PIC / training officer in the community. This will be a significant support and information resource to PIC in planning, managing and reporting on training delivery. The national HR lead will have organizational oversight of the training plan, its implementation and evaluation in the community. Full implementation 31/06/2020

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There are weekly conference call meetings for Persons in charge chaired by a CEO.
Regional managers chair monthly community learning group (CLG) meetings.
Regional Manager has oversight of all submissions to HSE safeguarding and HIQA notifications.
Safeguarding and NF06 notifications are reviewed by the regional safeguarding lead with overall oversight and audited by Principal Social Worker to ensure consistent quality in reporting.
A new safeguarding tracker has been designed and rolled out across the organization on 30/09/2019. This tracker is monitored by Person in charge, regional safeguarding lead and Principal Social worker.

In the community, daily checklists are completed by social care staff. These checklists are reviewed by the house coordinators who then provide a weekly report to the Person

in Charge. Any issues are then communicated by the Person in Charge with the regional manager along with monthly KPI reports.

The Head of Services and Regional Managers have reviewed (November 2019) their monthly monitoring visits to centres to systematically capture regulation 23 requirements and quality standards. These monthly visits will contribute to the Annual review of Q&S. For the Bridge Community annual review of quality and safety, all information has been gathered by the Person in Charge and processed by the provider, the report will be shared with Person in charge by the provider on 13/12/2019.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Issues highlighted during the announced inspection will be rectified. The resident contracts are currently under full review. All resident contracts will be reviewed and updated, families of residents any responsible signatories will be contacted regarding the change by 20/12/2019.
A working group is concluding its review of Admissions Transfer Discharge policy and the associated pathway and supporting assessments documents. This process will outline from early contact with the service the model and elements of service charges. This is to be completed by 20/12/2109

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The National operational review is currently ongoing. The whole-time equivalents of staffing levels are being reviewed under proposed community management structures and pending agreement at National level on whole time equivalents for social care staff.

All changes to whole time equivalents will be finalized and updated in the Statement of Purpose by 13/12/2019.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Local policies have been reviewed and are up to date as of 01/11/2019. Guidelines from National are that new national policies are being drawn up and will be disseminated to communities. These new national policies and procedures will take the place of the local policies and procedures.

National policies are being updated and shared with communities on an ongoing basis. The Senior Management Team is prioritizing policies for review / new policies which are required. A dedicated policy developer has been employed at national level. All operational policies are reviewed by the Quality and Safety working group before being passed to Senior Management Team and finally to Board for sign off, dissemination and training / implementation. Current prioritised policies of Senior Management Team will be in place 30/03/2020.
The National Risk Management draft policy is currently being updated.
The updated draft of the National Risk Management policy will be shared with the Person in Charge by 20/12/2019.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The National Health and Safety officer is currently reviewing the draft risk policy to incorporate reg. 26. The updated draft of the National Risk Management policy will be shared with the Person in Charge by 20/12/2019.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The safety systems in place in houses are monitored nightly by social care staff and weekly by house coordinators. Regular maintenance checks are completed by fire and safety contractor on a quarterly basis.
The remaining staff that require refresher fire safety training will have completed this by 04/12/2019.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Medication training is provided to social care staff by a registered nurse and then assessments are conducted by the community medication officer before social care staff are signed off as approved medication administrators.

HIQA document "Principles of good practice in medication reconciliation" now guides the community in this area, these principles have been shared with the medication officer and house coordinators by the Person in Charge.

In the community, daily checklists have been revised to include PRN medication counts. Detailed medication audit sheets have been developed to ensure oversight in this area. The house coordinator completes a weekly audit of the medications and documentation. A new medication officer was appointed on 05/10/2019 and inducted into the role. The medication officer conducts monthly audits and continuous assessment of each house's medication management practices, the first of which was completed on 09/11/2019 and improvement recommendations provided to Person in Charge and house coordinators.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Recently revised and updated personal care plan folders now include weight management section where the weight of the resident is recorded and documented every month. This is done in on the basis of consent with the resident on each occasion. Nutrition plans have begun to be developed with the residents which will include dietician input where necessary. The nutrition plans are guided by HIQA publication "Food and Nutrition guidance".

Health plans are being designed that will identify individual health assessment needs. This will then inform a calendar of appointments to monitor the individual health needs of the residents.
All residents and keyworkers will start developing nutrition plans and health plans by 02/12/2019.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

Clinical lead monitors the register of incidents of behaviours that challenge on a weekly basis and links in with Person in Charge regarding questions, observations or follow ups. Monthly and quarterly reports on BoC have commenced from data entered on behavior incident register. An analysis off data including trends from quarterly analysis is informing key information on BoC in the community and efficacy or otherwise of intervention plans.

Regular behaviour support reviews are scheduled with the next to take place on 18/11/2019. Here the behaviour support plans are reviewed and evidence of practice is gathered by Person in charge and Camphill Behaviour Support Lead.

The training plan includes Studio 3 training which trains staff in a low arousal approach to managing behaviours that challenge, remaining staff that require training in this are scheduled for 26th to 28th of November a final training completed by 13/12/2019.

Nationally Camphill is finalizing its strategic plan for behaviour support framework. This will be based on the Multi Element Behavioural Support model via Callan institute with supporting reactive measures / emergency response via Studio 3 and MAPS both of which are compatible with MEBS. A key outcome of the strategy will be skilled BS specialists in each region / based in community with skill and capacity to undertake assessment, intervention planning, plan implementation and review. This role and all individual intervention plans will be supported and overseen by the clinical lead.

All restrictive practices have been reviewed and are monitored and recorded daily. The Person in Charge reports any use of restrictive practices as part of the quarterly notifications process which was completed by 01/11/2019.

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 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	30/06/2020
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	13/12/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	06/01/2020

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/06/2020
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	13/12/2019
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.	Substantially Compliant	Yellow	13/12/2019
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and	Not Compliant	Orange	13/12/2019

	support in the designated centre and that such care and support is in accordance with standards.			
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	29/11/2019
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	20/12/2019
Regulation 26(1)(c)(i)	The registered provider shall ensure that the	Not Compliant	Orange	20/12/2019

	risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: the unexpected absence of any resident.			
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Not Compliant	Orange	20/12/2019
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Not Compliant	Orange	20/12/2019
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management	Not Compliant	Orange	20/12/2019

	policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.			
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	20/12/2019
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements	Substantially Compliant	Yellow	04/12/2019

	for the evacuation of residents.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	09/11/2019
Regulation 29(4)(c)	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 out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	09/11/2019
Regulation 03(1)	The registered	Not Compliant	Orange	13/12/2019

	provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.			
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	30/03/2020
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	02/12/2019
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	13/12/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or	Not Compliant	Orange	01/11/2019

	environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			