Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Camphill Ballymoney
Name of provider:	Camphill Communities of Ireland
Address of centre:	Wexford
Type of inspection:	Short Notice Announced
Date of inspection:	01 July 2020
Centre ID:	OSV-0003633
Fieldwork ID:	MON-0029608

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Wednesday 1 July 2020	09:30hrs to 16:30hrs	Tanya Brady	Lead
Wednesday 1 July 2020	09:30hrs to 16:30hrs	Sinead Whitely	Support

What residents told us and what inspectors observed

Inspectors had the opportunity to meet with five of the residents who live in this centre. At the beginning of the COVID-19 pandemic it had been agreed that one of the houses would be vacated so it could be used as an isolation location if required and therefore all residents now lived between two houses in this centre.

Inspectors observed residents at various stages of the day being supported to take walks, go into the garden or relax inside their home as well as to engage in their hobbies and crafts. One resident had been supported to take a trip to Dublin on the day of inspection and staff reported that the resident had been looking forward to this very much. Another resident met with one of the inspectors as they were making a willow basket, supported by staff. They explained to the inspector what they were doing and also how they usually enjoy local craft fairs and festivals in the summer. Another resident was watching a film on television and flicking through a magazine. On a chair nearby their cat was sleeping and the inspector was told how the resident loves to have the cat nearby and to stroke it when relaxing.

One resident communicated they felt happy living in the centre when asked, although also communicated that they sometimes don't always get along with a peer they lived with.

.

Capacity and capability

This was a risk based inspection, reviewing the governance and management of this centre in place to ensure good quality care and support was provided to residents. In addition to the structures and levels of accountability present to actively promote residents' well-being and independence.

Prior to this inspection, Camphill Communities of Ireland have been required to make a number of formal assurances to HIQA regarding the safeguarding of residents and the safety and quality of care delivered across a number of their designated centres. Safeguarding and quality assurances have been sought from the provider both nationally and at centre level.

Overall findings indicated poor levels of compliance in the designated centre. While residents appeared happy on the day of inspection, finding's indicated that residents did not always benefit from safe and effective systems to support them in

their everyday lives. Concerns in relation to safeguarding, staffing, the management of residents finances and the overall governance and management of the designated centre were raised as serious concerns on the day of inspection, as detailed in other sections of the report.

While staff and management were welcoming and available to the inspectors throughout the inspection day, inspectors found difficulties with accessing and reviewing some requested documentation. This inspection was short term announced and an inspector had contacted management two days prior to the inspection date, outlining documentation to have ready on the day for review. All requested documentation had not been furnished on arrival. Some additional documentation requests made on the day of inspection were also not provided.

There was a new person in charge who had recently taken over management of this centre. They are also person in charge in another of the providers' centres resulting in them having a large remit which is an area for review. They had initiated some centre specific reviews and had proposed some initial changes in practice for the staff team. They were supported by a house coordinator in each of the houses and inspectors met with both co-ordinators and the person in charge on the day. It was noted that a number of the systems such as the layout of residents' personal files differed between the houses and there was no one overarching system in place.

The six monthly unannounced visits undertaken on behalf of the provider, as required by regulation, had not been completed since May 2019 and as a result there were no reviews and actions identified. Additionally, the inspectors found that robust auditing systems had not been consistently applied which would support better on-going review of care. The annual report for 2018 was available but none had been completed for 2019.

A core group of consistent staff was employed however the skill mix of staff required review and the inspectors were informed that interviews had been initiated to recruit social care workers. There was an on call system in place which was shared with another centre nearby. The inspectors reviewed the staff rosters in place and noted that they were incomplete and did not reflect the staffing position on a given day, with some staff not appearing on the roster and for others not all days/hours were recorded. Rosters did not reflect what staff were working in which of the two separate houses of the designated centre.

From a review of a sample of personnel files the inspectors found that the required documents were not in place. Staff documentation and recruitment systems were not being implemented and reviewed in line with the organisational policy. This had been self-identified by an audit completed by the person in charge. Following a review of this audit and the staff files, and conversations with the person in charge, it was identified that three staff members did not have up-to-date An Garda Síochana vetting in place. The person in charge communicated that the vetting application was in process and confirmation was still pending. Information was submitted to the inspectors immediately following the inspection day, confirming that required vetting by An Garda Síochana was in place for all staff. This had not been demonstrated to inspectors on the day of inspection. In addition to this, two

staff members were also identified as having no references in place and one staff member had no contract in place or details of their commencement date, as required by Schedule 2. Overview of support and care was implemented on a day to day basis by the house coordinators who were based within the two houses. However, organisational policy stated that formal staff supervisions was required every two months. This was not taking place. All staff, except two, were overdue a supervision with a line manager. Seven staff members had never completed an appraisal and this was required to be completed annually as per the providers own organisational policy.

From a review of the staff training records, the inspectors observed that staff training was provided in areas including safeguarding, children first, fire safety, manual handling, first aid, epilepsy management and behaviour management. However, some mandatory training was not up to date for all staff. Six staff members were identified as needing either initial or refresher fire safety training. COVID-19 had contributed to a delay in the delivery of training for some of these staff members. All staff however who spoke with the inspectors demonstrated a sound knowledge of the residents' needs and preferences and residents were observed to be comfortable and interacting easily with the staff in their home.

The inspectors reviewed all contracts of care for residents' that were available and noted they did not contain all the information required by the regulations including charges and additional charges which residents were responsible for in relation to their day-to-day care and support. While the provider reported that they were reviewing and devising a new contract these were not in place on the day of inspection although a sample of these was seen. For one resident the contract in place was for a different centre, signed in 2014 and they had no contract in place for the home they currently lived in.

Regulation 15: Staffing

Inspectors reviewed the staff rosters in place and noted that they were incomplete and did not reflect the staffing position on a given day, with some staff not appearing on the roster and for others not all days/hours were recorded. Rosters did not reflect what staff were working in which of the two separate houses of the designated centre.

From a review of a sample of personnel files the inspectors found that the required documents were not in place, checks were not consistently being completed in line with the organisational policy.

Judgment: Not compliant

Regulation 16: Training and staff development

From a review of the staff training records, the inspectors observed that staff training was provided in areas such as safeguarding, manual handling, however, mandatory fire safety training was not up to date for all staff. In addition, formal staff supervision was not occurring in line with providers policy.

Judgment: Not compliant

Regulation 21: Records

From a review of a sample of records the inspectors found that records were not kept as required in Schedule 2, 3 and 4, such as records relating to the receipt of valuables for residents or the duty roster.

Judgment: Not compliant

Regulation 23: Governance and management

Governance and management of this centre was found to be poor. Oversight systems were not effective and did not ensure the delivery of safe and quality care to residents.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Contracts of care for residents' that were available did not contain all the information required by the regulations including charges and additional charges which residents were responsible for in relation to their day-to-day care and support

Judgment: Not compliant

Regulation 4: Written policies and procedures

The policies reviewed by the inspectors had not been reviewed by the provider as

required by the regulation and were not used to guide practice.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found residents' support while facilitated in a person-centred manner required improvement. The inspectors found that significant improvements were required by the provider in areas such as safeguarding residents, supporting residents with the management of their personal possessions and in the management of risk in the centre. In addition to other areas reviewed, this inspection afforded review of the infection control measures in place, in light of the COVID-19 pandemic.

The centre presented as a clean, warm and homely environment and this was evident in the two houses the inspectors visited. Each resident had single bedrooms which were decorated in line with their personal interests and tastes and there was evidence that residents where possible were supported to maintain their own personal space. In one of the houses a large living room had an area with a table set aside for residents to access hobbies such as jigsaw making or fabric weaving and the inspectors could see examples of these in place.

Some improvements were noted to be required in overall fire safety systems and containment systems in the designated centre. The door into a bedroom was noted to be propped open with a waste bin and a clothes horse behind the fire door into the utility room prevented it from fully opening. Another door leading from a kitchen area was observed as open and not connected to a closure system in the event of a fire. In addition to this, a number of fire doors throughout the centre that supported areas of containment were not closing as required.

The inspectors found practices relating to the safeguarding of residents personal possessions to be inadequate. Where residents had the providers money management assessment completed, these had not been updated in line with the providers' policy and residents consent had not been obtained for the actions arising from these assessments. Inspectors reviewed financial records for a number of residents and it was noted that some had not been completed within in the last year. Additionally, there were no audits on the resident financial records or checks on the tallies occurring. Inspectors observed incidents where staff had recorded residents spending on pieces of paper and post-it notes and had not obtained receipts in line with the organisational policy. A spot check was completed on the day of inspection between total amounts recorded that should be present and amounts actually present and none of those reviewed correlated. It was unclear as to the extent of some residents' involvement in decisions around their own finances and whether they had been consulted about who would take responsibility in managing their money. Where it was not the resident themselves or the provider,

there was a lack of clarity on whether residents' money was fully accessible to them or being managed in a transparent manner. Where residents required/did not require the support of staff/co-workers it was not clear whether consent had been formally obtained. In some instances reviewed whereby residents were determined to have capacity, the provider determined that in these cases they kept no records of any of the residents' expenditure or receipts/records. In the absence of an appropriate assessment of capacity this was considered to be a significant risk area by inspectors.

The provider had ensured systems were in place to protect residents from abuse. However, there was evidence that some incidents had not been identified as safeguarding concerns and as such addressed in an appropriate manner. These included situations where others had access to residents' monies and no oversight from the provider was in place to ensure residents were safeguarded by having their money returned.

There were risk management arrangements in place which included environmental and individual risk assessments for residents. Most outlined appropriate measures in place to control and manage the risks identified. However, in some of the risk assessments reviewed by inspectors it was apparent that the impact of the risk and control measures in place were out of date or incorrect despite the overall assessment recorded as having been reviewed. Where residents presented with vulnerabilities and potential high risks secondary to lack of oversight of financial management systems this risk was not consistently identified, assessed, or mitigated.

Inspectors noted both houses in the designated centre were visibly clean. Hand washing facilities, alcohol gels and personal protective equipment (PPE) were readily available in the houses. Staff were completing regular temperature checks and recording any contact in the designated centre. Emergency contingency plans had been developed in light of the recent COVID-19 pandemic. Guidance on infection prevention and control was available to staff and residents. However, guidance in place for staff on the use of face masks was not in line with national guidance. Staff members were observed working within 2 metres of residents without donning facemasks on the day of inspection.

Regulation 12: Personal possessions

Safe and effective systems for the management of residents' personal possessions were not in place. Where residents required support it was not clear that consent had been obtained in all instances.

Judgment: Not compliant

Regulation 17: Premises

This centre presented a clean, warm, homely environment where residents had single bedrooms which were decorated in line with their personal interests and tastes.

Judgment: Compliant

Regulation 26: Risk management procedures

There were risk management arrangements in place which included environmental and individual risk assessments for residents. Some residents presented with vulnerabilities and potential high risks secondary to their levels of capacity and financial management systems. The majority of residents did not have this risk identified, assessed, or mitigated where possible.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Provider guidance for the use of face masks was not in line with national guidance furthermore staff were seen not to observe best practice with the use of PPE while supporting residents.

Judgment: Not compliant

Regulation 28: Fire precautions

While the provider had the taken adequate precautions against the risk of fire and there was suitable fire fighting equipment available the arrangements for containing fires required review. A number of doors in place to support areas of containment did not close as required and a request was made to complete work on these was made on inspection. Additionally some of the identified escape routes required items removed to ensure they were fully accessible, this was completed on the day of inspection.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had ensured systems were in place to protect residents from abuse. However, there was evidence that some incidents had not been identified as safeguarding concerns and as such addressed in an appropriate manner. Financial safeguarding was of particular concern given the absence of clear and consistent practices to protect same.

Judgment: Not compliant

Regulation 9: Residents' rights

The person in charge and staff team were endeavouring to uphold residents rights in this centre however there was limited evidence that residents had consented to decisions and supports in relation to their care and support.

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	Not compliant
Regulation 21: Records	Not 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 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Camphill Ballymoney OSV-0003633

Inspection ID: MON-0029608

Date of inspection: 01/07/2020

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. The PIC has introduced a new rostering template, this template highlights staff assigned per shift, grade, and contracted hours. This template and system is now operational within Ballymoney Community.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. Fire training records have been reviewed and a number of staff have received fire training on the 06/08/2020 from Antifire Services. A further training date has been arranged for the 10/09/2020 to ensure all staff members have received up to date fire training. All staff will have received fire training within the Centre by the 10/9/2020. 2. PIC has reviewed all other training and scheduled further training dates to ensure staff are provided with the required knowledge and skills 3. Schedule of Supervision for frontline staff in place and operational from 11/08/2020. PIC will oversee this monthly with the House Co-ordinator. 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.	

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. The PIC has conducted a full review of all HR files within Ballymoney Community. The outstanding actions identified will be addressed and records brought into line with schedule 2 by 31/09/2020. Garda Vetting fully updated

2. Personal Asset register being updated for each resident and review of Money management assessments and residents personal finance records to be completed by 14/8/20. Daily reconciliation and sign off.

3. Internal unannounced inspection completed 30/6/20 and external unannounced inspection completed **. Annual Review scheduled for 30/9/20

4. Standard internal audit tools has been developed and will be implemented at Ballymoney from September actions for improvement will be logged on a Community Improvement plan with regular review meetings involving the Head of Service/Regional Manager/Local Management and the heads of functions to progress these actions . Ballymoney review meeting taking place fortnightly with HOS/RM and PIC for August and September to ensure compliance actions have been addressed.

5. Review and restructuring of files to be undertaken for Ballymoney with the local teams in line with a new standard CCoI File Architecture system and supported by the National Governance team. A standard file audit tool has been developed, spot checks will take place by PIC/RM/Clinical Support officer and its anticipated that all files will be reviewed and restructured by end September.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. CCol have acknowledged the large remit of the current PIC, CCoI have recently advertised for a PIC specifically for Ballymoney Community, ensuring oversight and systems implementation, interviews are scheduled for 13/8/20 and it is anticipated that the new PIC will be in position by 30/09/2020.
2. CCoI has advertised for the position of Day Service Co-ordinator to manage day services across Ballymoney and Duffcarrig, this will promote greater governance and management and increase the capacity of the PIC's to concentrate on the residential services.

3. New CCoI operations management and governance structure is being rolled out at Ballymoney commencing on 23/7/20 and an implementation plan as been developed for Ballymoney. This involves a systematic approach to operating and managing services, across the CCoI communities which commenced with 3 communities including Ballymoney. Standard documentation have been put in place for daily reporting, house, and community level management together with a standard PIC/Q&S Officer audit, which involves documented checking of all documentation regarding schedule 2 (staffing), training, risk management, residents finances, residents files, clinical support and records. The process for 6 monthly Reg 23 inspection systems has been strengthened and systems developed for internal auditing which have been applied in the community
4. The PIC and Q&S lead have 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,
5. A community SharePoint site is in the process of development for Ballymoney creating the infrastructure for increased oversight. where all records are stored, increasing the level of oversight for the PIC at house level, and above.
6. There will be a national schedule to ensure that Reg 23 Unannounced Inspections are be completed 6 monthly in all Communities. An annual review will be completed by end of September.

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.

2. The PIC has conducted a review ensuring during the interim period that all contracts of care are recorded and stored in the appropriate place.

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 by 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. Ballymoney will pilot this new SOP from September 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.
5) PIC/Quality and Safety Officer walkarounds and auditing systems being implemented
6) CCoI have recently appointed persons into key national positions, HR, Finance, Regional Operational Management, Regional Safeguarding Lead, Clinical Lead.

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. Ballymoney will pilot this new SOP from September 2020.
2) The PIC has instructed and spot checked that all residents receive a money management assessment, a completed inventory list of possessions supported by an informed risk analysis any ambiguities or high risk assessment will be reported accordingly, these measure will be in place by the 14/08/2020.
3) The PIC is currently rolling out new Organizational systems and processes of recording residents' financial transactions and matters providing daily, weekly monthly, oversight full implementation is expected to be reached by 30/09/2020.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1) The PIC is currently rolling out new Organisational systems and processes of recording residents' financial transactions. This will provide daily, weekly, and monthly oversight promoting greater governance and management. Full implementation is expected to be reached by 30/09/2020. The PIC has instructed that all residents receive a money management assessment, a completed inventory list of possessions supported by an

informed risk analysis. Any ambiguities or high-risk assessment will be reported accordingly, these measures will be in place by the 14/08/2020.

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 the 31/08/2020. 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 Officer walkarounds and auditing systems will include inspection on infection control

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1) The PIC has scheduled maintenance at Ballymoney Community and addressed any issues that had been high-lighted during the inspection, as of 07/08/2020 all outstanding matters have been addressed. 2) The PIC has instructed that the recent Health and Safety Audit conducted by the National Health and Safety Coordinator in April be reviewed and ensure all actions are completed and closed off by the 30/9/2020 3) All staff will have received fire training by the 10/09/2020.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: 1) For residents with no next of kin advocacy referrals will be made by the PIC and

circles of support created to ensure the transparency of decision-making line with the will and preferences of person e.g. finances, end of life decisions, wills etc. will be incorporated into plan supporting residents wishes, choices and opportunities, this will be completed by 15/10/2020 and recorded in their personal plans 2) Other actions undertaken to address identified gaps in finances have been identified above.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: 1) CCoI are currently engaging with Residents on new contracts of care which will be implemented in September. All contracts will be discussed with residents and Independent Advocates will be invited to be part of those discussions where requested.	

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	14/08/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/09/2020
Regulation 15(4)	The person in charge shall	Not Compliant	Orange	07/08/2020

	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.			
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	30/09/2020
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.	Not Compliant	Yellow	10/09/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	07/08/2020
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in Schedule 2 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	30/09/2020
Regulation	The registered	Not Compliant		30/09/2020

21(1)(b)	provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.		Orange	
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not 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' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	15/11/2020
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.	Not Compliant	Orange	30/12/2020
Regulation 23(2)(a)	The registered provider, or a person nominated	Not Compliant	Orange	30/12/2020

	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.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Yellow	15/11/2020
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of	Not Compliant	Orange	30/09/2020

	giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	30/09/2020
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	15/11/2020
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	Not Compliant	Orange	30/08/2020

	healthcare associated infections published by the Authority.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/09/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	10/09/2020
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	30/12/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	14/08/2020
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take	Not Compliant	Orange	30/09/2020

	appropriate action where a resident is harmed or suffers abuse.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	30/09/2020