Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Camphill Ballymoney
Name of provider:	Camphill Communities of Ireland
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	07 August 2019
Centre ID:	OSV-0003633
Fieldwork ID:	MON-0024689

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 two-storey 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:	6

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
07 August 2019	10:20hrs to 18:50hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

The inspector met five of the six residents who were living in this designated centre at the time of this inspection. Some of these residents were met only briefly and the inspector did not have an opportunity to directly obtain all residents' views regarding the designated centre where they lived and the services they received. However, some residents did speak with the inspector while others were observed as they spent time in their homes.

On arrival in one unit of this centre, the inspector met all three residents who lived in this unit. The residents were preparing to go to another unit of the designated centre to support with some spring cleaning. One of these residents greeted the inspector and seemed very happy in their surrounds. This resident was being supported by a volunteer at the time and appeared very comfortable with this.

A second resident was in the process of having their breakfast and also greeted the inspector. This resident seemed relaxed in the presence of staff and volunteers on duty. The third resident spoke with the inspector briefly and asked why the inspector was visiting this unit. This was explained to the resident who subsequently indicated that things were good in the unit. Shortly after, this resident was observed to be carrying out her own laundry before leaving the unit.

The inspector visited a second unit of the centre where two residents were living and had an opportunity to speak to one of these residents. Permission was given by this resident for the inspector to review their individual personal plan. The resident also talked about some forthcoming activities they were going to undertake such as going out for a coffee, getting a haircut and attending a barbecue. The resident appeared to have a positive relationship with the staff member on duty.

The second resident who lived in this unit was not present at the time of the inspector's visit there as they had left earlier in the day on an overnight stay away in a city hotel with the support of staff. One resident was living in the third unit of this centre. While this unit was not visited during the inspection, the inspector did meet this resident briefly who greeted the inspector before speaking to the person in charge. Later on the resident was supported by staff to go on an outing to a garden centre.

Capacity and capability

Residents were being supported to enjoy a good quality of life while they lived in this designated centre. It was noted though, that the structure which the provider had put in place for the running of the centre was not ensuring that the person in

charge could effectively carry out all of their duties under the regulations.

This designated centre was made up of a total of three units, two of which were visited by the inspector, with support to residents provided by a combination of paid staff members and volunteers. Each unit had an individual staff member assigned as a house coordinator, all of whom worked directly supporting residents and who were each involved in the day-to-day operations of their assigned unit. The three house coordinators made up the management team for this centre. The person in charge was appointed to this role in December 2018 and also served as one of the house coordinators at the time of this inspection. Prior to their appointment to this role, the person in charge had already been a house coordinator and it was noted that the previous person in charge had worked above the three house-coordinators, did not work front-line shifts and was afforded protected time to carry out their duties.

However, the structure which the provider had put in place for the designated centre since December 2018 did not provide the same level of support for the current person in charge. As a result the person in charge was not adequately facilitated to discharge all of their regulatory duties. For example, some areas, which were found to be in need of improvement during this inspection, were the direct responsibility of the person in charge under the regulations. These included the maintenance of staff rosters, medicines practices and residents' personal plans. It was also observed that since the appointment of the person in charge to this role, there had been limited auditing carried out in the centre. Such auditing is important to assess, evaluate and improve the service provided, in a systematic way. While the provider did carry out their own annual reviews and provider unannounced visits, improved auditing at a more local level would likely have identified some of the issues highlighted before this HIQA inspection took place.

While the structure and management systems in place required improvement, some of the issues identified during this inspection did not necessarily pose a high risk to residents and overall it was seen that residents were supported to enjoy a good quality of life in keeping with the community ethos of the provider. This was aided by the level of need of the residents living in the designated centre and the overall staffing arrangements, as supported by the provision of volunteers, which had been put in place. It was noted that, since the previous HIQA inspection in February 2018, the number of staff members working in the centre had increased while the amount of volunteers had decreased. Staff members spoken with during this inspection demonstrated a good knowledge of residents' needs and how to support them while a volunteer was observed to provide appropriate support to one resident.

The provider had made efforts to ensure that residents were provided with a continuity of staff support which is important to ensure consistent care and maintain professional relationships. It was noted that there was some use of staff from an external agency but the inspector was informed that approval had been obtained for additional staff to be hired by the provider which would reduce the use of agency staff. It was also seen that the most recent member of staff employed by the provider to work in this centre was already familiar with residents having worked there as an agency staff member previously. Throughout the inspection it was

observed that residents appeared comfortable and relaxed in the presence of staff members and volunteers on duty, while there appeared to be positive and warm relationships between some residents and some staff members.

Staff files were maintained in the designated centre which included most of the required information such as proof of identification, written references and evidence of Garda Síochána (police) vetting. Such files are important in reviewing the recruitment practices adhered to by a provider. It was noted though that complete files for some staff, particularly agency staff, did not include all of the information required by the regulations. This was highlighted to the person in charge who indicated that efforts were under way to ensure that complete files for all staff members were obtained going forward. Volunteer files were also present in the centre which included records of Garda vetting but not written roles and responsibilities as required. When reviewing staff and volunteer files it was noted that formal supervisions were not taking place in a consistent manner.

Regulation 15: Staffing

Appropriate staffing arrangements were in place to support residents at the time of this inspection. Rosters were maintained in the designated centre but the actual rosters worked required improvement to clearly show the hours worked and the names of agency staff who worked particular shifts. Staff files were present for staff members employed by the provider which included evidence of Garda vetting but complete staff files were not maintained for all staff members particularly agency staff members.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training was provided to staff members in areas such as manual handling, safeguarding and epilepsy. Arrangements were in place for staff members to receive supervision but there was inconsistencies as to when formal supervisions were taking place.

Judgment: Substantially compliant

Regulation 23: Governance and management

The structure which had been put in place for this designated centre was not ensuring that the person in charge could fully discharge their duties under the

regulations. There had been limited auditing in the centre throughout 2019. A six month provider unannounced visit to the centre had not been carried out between November 2017 and November 2018. An annual review had been carried out for 2018 which outlined how the provider consulted with residents and their representatives but did not clearly indicate what their views were on the designated centre.

Judgment: Not compliant

Regulation 30: Volunteers

Evidence of Garda vetting was in place for volunteers involved in the designated centre. These were included in files maintained for volunteers but it was noted that such files did not include roles and responsibilities for the volunteers that were set out in writing. Formal supervisions for volunteers were not taking place in a consistent manner.

Judgment: Substantially compliant

Quality and safety

Residents were being supported in engage in various activities which promoted a good quality of life for them. It was noted though that medicines practices and documentation were not in keeping with best practice while some aspects of residents' individual personal plans required review.

The provider was making active efforts to ensure that each resident enjoyed the best possible health. Residents had specific medical folders in place which included records of reviews by allied health professionals such as general practitioners and psychiatrists. While reviewing one resident's medical file it was noted that reviews by two particular allied health professionals, as recommended in May 2018, had yet to take place at the time of inspection although efforts were being made to follow up on these. Residents' medical files also contained documentation relating to medicines which residents were prescribed and supported to take to maintain their health. However, from reviewing a sample of this documentation it was clear that medicines practices within the designated centre were not in keeping with best practice.

For example, records reviewed indicated some residents did not receive their medicines at the prescribed time of day on a consistent basis while some medicines records in use did not clearly state the times residents were to receive their medicines. The inspector reviewed the medicines storage facilities in the two units

visited. In one it was noted that the storage facilities in use required review to ensure security but the inspector was informed that new storage facilities were in the process of being obtained. However, while reviewing this storage, the inspector observed two medicines which had clear directions to be discarded after a particular period of time once first being opened. The dates these medicines were first used were not indicated on them, in line with best practice, while the inspector was informed that one of these medicines would have been used after the time when it should have been discarded.

While medicines practices and documentation were areas in need of improvement, the inspector did see good instances of practice elsewhere. For example, the provider sought to promote the rights of residents by consulting with them and giving them information to help them to exercise their right to vote. It was seen that residents were supported in a wide range of activities in keeping with the community ethos of the provider. Such activities included arts and crafts, gardening, basketry, weavery, bocce, gardening and dancing. Residents were also facilitated to engage in various community based activities such as library visits, going to the cinema, walks on a nearby beach, travelling to cities for overnight stays away or to see shows and attending a local gym/swimming pool. Support was also given for residents to reach their potential with educational opportunities, such as literacy classes, facilitated. This provided assurances that arrangements were in place to meet the needs of residents living in this centre.

Residents' needs were set out in their individual personal plans. From a sample of such plans reviewed it was noted that these have been developed following assessments which focused on particular areas relating to residents' health, personal and social needs. The outcome of such assessments were reflected in the personal plans outlining the support residents were to receive to support their needs. While generally these plans contained good guidance it was noted that some communication plans did not clearly set out how to communicate with residents and how to support residents in improving their communication, although staff members spoken with during inspection did demonstrate a good awareness of residents' communication needs. As required by the regulations, residents and their families were involved in reviewing personals plans annually but it was observed that some parts of the personal plans seen by the inspector had not been reviewed in over 12 months which included specific safeguarding plans.

However, it was acknowledged that such safeguarding plans were not present at the time of the previous HIQA inspection in February 2018 and these had been put in place for residents since that time. That inspection also highlighted the need for intimate personal care plans to take account of the use of therapeutic oils to safeguard residents' dignity and bodily integrity. On the current inspection the inspector was informed that such therapeutic oils were no longer used and it was found that intimate personal care plans remained in place to guide staff practice. During inspection, residents were observed to be comfortable in the presence of staff members and volunteers on duty. Training records reviewed indicated that the designated centre's workforce was provided with relevant safeguarding training while it was also seen that any safeguarding concerns that arose were reported and investigated. It was observed though that aspects of the processes concerning

residents' finances required review to ensure that they operated to sufficiently protect residents from the possibility of suffering financial abuse. However, the inspector did not observe any evidence that residents' finances were being misappropriated during this inspection.

The provider had ensured that other measures were in place to ensure the safety of residents while they lived in this designated centre. For example, an emergency plan that had been reviewed in January 2019 was provided which outlined what to do in the event of particular adverse incidents such as fire and power loss impacting the centre. Appropriate fire safety systems were also in place in both of the two units visited by the inspector which included fire alarms, emergency lighting, fire doors and fire extinguishers. During inspection it was seen that the fire alarm in one unit was being checked by an external contractor to ensure that the alarm was in proper working order. It was observed though that the use of fire doors in both units visited, which are designed to reduce the spread and fire and smoke while providing residents with a protected evacuation route should a fire occur, required review to ensure that they operated correctly. Fire safety training was provided to staff but it was noted that some staff had yet to receive training in the use of fire fighting equipment at the time of inspection.

Regulation 10: Communication

Staff members spoken with demonstrated a good understanding of residents' communication needs. Communication plans were in place for residents but it was noted that some of these required review to ensure they they provided clear guidance for staff on how to communicate with residents and how to support residents in improving their communication.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents were supported to engage in various community based activities such as attending the library, cinema visits, walks on the nearby beach, visits to garden centres and going swimming. Residents were facilitated to participate in activities which were of interest to them including arts and crafts, while residents were also supported to pursue educational opportunities such as literacy classes.

Judgment: Compliant

Regulation 26: Risk management procedures

An emergency plan was in place for this designated centre which covered potential adverse events which could impact the centre such as fire and loss of power. This emergency plan included details of possible alternative accommodation if needed and emergency contact numbers. Risk assessments were in place relating to identified risks outlining the controls to reduce the potential likelihood of such risks. It was noted though that some risk assessments had not been reviewed in over 12 months.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire doors were present in the two units visited by the inspector but it was observed that the use of some of these doors required review to ensure that they functioned as intended. Other fire safety systems in place included fire alarms, emergency lighting and fire extinguishers. Fire drills were carried out regularly and the fire evacuation procedures were seen to be on display in both units visited. Fire safety training was provided to staff but it was noted that not all staff members had received training in the use of fire fighting equipment.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medicines documentation and practices in use required improvement to ensure that residents received their medicines as prescribed. The storage facilities in one unit did not ensure the security of medicines stored there.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Assessments of residents' health, personal and social needs had been carried out in the previous 12 months. These informed individual personal plans that were in place for residents which provided guidance for staff and volunteers in how to support residents. It was noted though that some parts of the plan had not been reviewed in over 12 months. Based on the overall findings of this inspection, arrangements were in place to support the assessed needs of residents living in this designated centre.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to maintain their health and care plans around specific healthcare needs were in place. General practitioners reviewed residents as required but it was noted that reviews by two particular allied health professionals, as recommended for one resident in May 2018, had not happened at the time of inspection.

Judgment: Substantially compliant

Regulation 8: Protection

Residents had intimate care plans in place to provide guidance for staff in maintaining residents' dignity and bodily integrity. Issues of a safeguarding nature were being reported and investigated. Relevant safeguarding training was being provided to staff and volunteers. The processes in place relating to residents' finances required review to ensure that they operated to protect residents from the possibility of financial abuse taking place. Safeguarding plans were in place for residents but it was noted that some had not been reviewed in over 12 months.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There were systems in place for residents' rights to be assessed while they lived in the designated centre. Evidence was seen that residents were also given information to support them in exercising their right to vote. Residents were consulted in relation to the running of the designated centre with regular resident meetings held in each unit of the designated centre.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	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	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Camphill Ballymoney OSV-0003633

Inspection ID: MON-0024689

Date of inspection: 07/08/2019

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Current roster format is being improved to include specific agency staff names and clearly show hours worked. Completion date 20/09/2019 Schedule 2 compliance pack has been obtained from Agency in respect of any agency staff working in the Centre. Completion date 08/08/2019 The PIC will ensure all information and documents specified in Schedule 2 are maintained. As part of schedule of audits proposed in response to Regulation 16 an audit of HR schedule 2 compliance will be carried out. The PIC in conjunction with the regional manager will develop an audit schedule for the remainder of 2019 and for 2020. Auditing against this schedule will commence from 15/09/2019 and will focus initially on medication management and administration, communications updates within PCP, and HR files and audit supervision of staff and volunteers. Completion 2019 audit schedule 15/09/2019 Completion audit plan 2019 by 15/12/2019	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: As an organisation staff development is encouraged. Staff receive supervision regularly in an informal manner, members of management are always available in person or by phone if staff wish to discuss any issues they may have.	

Formal staff supervision schedule including volunteers to be drawn up and implemented outlining staff supervisions to take place no less than a six weekly cycle or more frequently if needed. Each manager will maintain an up to date schedule of supervisions for their staff. The PIC will receive a two monthly update supervision reports from House and ensure all staff supervision are taking place. Completion date 29/09/2019.
The PIC in conjunction with the regional manager will develop an audit schedule for the remainder of 2019 and for 2020. Auditing against this schedule will commence from 15/09/2019 and will focus initially on medication management and administration, communications updates within PCP, and HR files and audit supervision of staff and volunteers.
Completion 2019 audit schedule 15/09/2019
Completion audit plan 2019 by 15/12/2019

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The centre had gone through a significant change in structure including change in management roles and responsibilities from the end of 2018 into January 2019. This period saw the long-term volunteers leave the community and led to a change in roles and duties for the PIC which included taking on roles in recruitment HR admin, payroll admin and finance / accounts management. The PIC also held a shared role as House Coordinator for one home during 2019.
To refocus the core role and resource of the PIC to the key functions of oversight and monitoring of care and support to residents, and of management and oversight of the staff team the provider is making the following changes.
The current functions associated with payroll, finance and HR administration will be moved in line with operational plans to centralise key aspects of these functions at national level. The PIC will retain responsibilities for oversight of the functions locally as they impact on provision, but the administration will be provided nationally.
The current House Coordination role of the PIC for one unit will be replaced by a current House Coordinator taking responsibility for this role which supports one person.
The combined impact of these changes will provide 10 additional hours to the PIC per week. These ten hours will be prioritized in the areas of audit, assessment and evaluation of provision locally by the PIC. Completion date 30/09/2019
The PIC will also take the lead in the populating of the centre registers for accidents, incidents, medication errors and complaints. These returns will feed into national clinical lead. The information gathered from the last quarter of 2019 will generate initial trending reports to further inform learning and corrective actions in the centre. .
Safeguarding data is equally being collected and collated by the National Safeguarding lead.
Completion date for first quarterly reports from clinical lead 31/01/2020
The PIC in conjunction with the regional manager will develop an audit schedule for the

remainder of 2019 and for 2020. Auditing against this schedule will commence from 15/09/2019 and will focus initially on medication management and administration, communications updates within PCP, and HR files and audit supervision of staff and volunteers. Completion 2019 audit schedule 15/09/2019
Completion audit plan 2019 by 15/12/2019
The Head of Services will develop a schedule of unannounced six-monthly inspections with the regional manager for 2019 / 2020. The provider has recruited a new regional manager to replace an existing vacancy this post will commence nationally on 3/09/2019
Audit schedule for regional management unannounced inspections for the centre will be completed 15/09/2019.

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
The provider conducted and independent review of the of volunteer in the organisation in 2018. An implementation working group was established to review the role and functions of the short-term volunteers within the overall context of service provision and as key contributors to the ethos and model of community as operated by the provider. The implementation group commenced its work in August 2019. The first task has been to a to gather information through a survey of each community on the specific roles and functions of the volunteers in each community. The outcome from this key action of the implementation group will inform the review of the role description, duties and responsibilities of volunteers in the centre. Completion date 15/12/2019
An interim job description with roles and responsibilities specific to this centre will be put in place. All volunteer will receive a refresher in their induction / orientation
in their job description and expected roles and responsibilities
Completion date 30/09/2019
A supervision schedule will be developed and maintained by the house coordinator in each unit as referenced above in response to Regulation 16 This will ensure formal supervision of volunteers is taking place and records of same will be maintained.

plan
Completion date of revised management of volunteer supervision process 27/09/2019

Supervision policy to be reviewed as part of national policy review process 31/01/2020

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication: Communication plans to be updated in consultation with residents and reviewed with all staff and volunteers. Staff and volunteers will receive training on implementation of revised communication plans Completion Date 13/09/2019	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Full internal individual risk assessments review to be carried out by house coordinators and signed off by the Person in Charge. Completion date 06/10/2019	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire Doors will be reviewed. Completion date - 06/11/2019 All staff have now received training in the use of firefighting equipment. Completion date - 03/09/2019	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: New medication storage facilities ordered for all units. Awaiting delivery - expected 9th-13th/9/19 Completion date 23/09/2019 Clinical lead will have oversight to review medication management and oversee reporting of trends in relation to medication management errors. Revised training program has commenced and is currently being rolled out by clinical	

lead.
All medication administration times will be reviewed in consultation with GP. Completion date: 23/09/201.ll Kardex/ Mars sheets to be reviewed by House coordinators in conjunction with G and pharmacists involved.
Completion date 23/09/2019

A medication audit was conducted and any out of date medication was discarded in line with best practice.

Completion date 08/08/2019

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All PCPs to be updated and reviewed. Schedule of PCP reviews to be introduced and monitored by PiC.
Completion date 27/09/2019

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Some health assessments had not been reviewed within 12 months as public waiting lists exceed that time frame
Business cases for additional funding were submitted 08/08/2019 to the HSE. Awaiting response from the HSE Resident is not in a financial position to privately fund assessments.

Access to assessment will be reviewed monthly.

Completion date 27/11/2019

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: A review of financial management arrangements has been carried out so that there is separation of duties in support arrangements and improved management oversight Completion date 27/08/2019 An audit of financial management will be carried out on a monthly schedule. Completion date 27/09/2019All safeguarding plans to be reviewed/updated Ongoing/ Completion date 27/09/2019	

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 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	12/08/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	20/09/2019
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.	Substantially Compliant	Yellow	12/08/2019

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	27/09/2019
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	15/09/2019
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	12/08/2019
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	15/09/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall	Substantially Compliant	Yellow	31/12/2019

	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 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	06/10/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	03/09/2019
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency	Substantially Compliant	Yellow	03/09/2019

	procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	23/09/2019
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom	Not Compliant	Orange	23/09/2019

	it is prescribed and to no other resident.			
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	23/09/2019
Regulation 30(a)	The person in charge shall ensure that volunteers with the designated centre have their roles and responsibilities set out in writing.	Substantially Compliant	Yellow	08/08/2019
Regulation 30(b)	The person in charge shall ensure that volunteers with the designated centre receive supervision and support.	Substantially Compliant	Yellow	20/09/2019
Regulation 05(6)(c)	The person in charge shall ensure that the	Substantially Compliant	Yellow	27/09/2019

	personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	08/08/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	27/09/2019