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:	Carrick on Suir Camphill Community
Name of provider:	Camphill Communities of Ireland
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	17 August 2021
Centre ID:	OSV-0003608
Fieldwork ID:	MON-0032378

About the designated centre

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

Carrick on Suir Camphill Community, located in a town, provides long-term residential care to both male and female residents over the age of 18 with intellectual disabilities, autism and physical support needs who require medium levels of support. The centre comprises of seven units in total combining a mixture of residential houses and individual semi-independent supported houses. All residents have their own bedrooms and facilities throughout the units which make up this centre include kitchens, sitting rooms, dining rooms and bathroom facilities. In line with the provider's model of care, residents are supported by a mix of paid staff (including a nurse and social care staff) and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 17 August 2021	10:00hrs to 20:00hrs	Tanya Brady	Lead
Tuesday 17 August 2021	10:00hrs to 20:00hrs	Conor Dennehy	Support

What residents told us and what inspectors observed

This inspection was undertaken to ensure a good quality of care and support was being delivered to residents in this centre. This inspection sought to verify actions that the provider had outlined in their six month national improvement plan, as submitted to the Chief Inspector of Social Services, which concluded in April 2021 and to follow up on assurances provided following an inspection of the centre in December 2020. This inspection was carried out by two inspectors and all units that make up this designated centre were inspected. The inspectors met with all residents present in the centre on the day of inspection and met with members of the staff and management team.

Overall, the findings of this inspection were that while improvements continue to be found across a number of areas, there remains high levels of non-compliance with regulations.

A number of improvements have arisen following a recent change in management and in staffing levels within the centre. The residents who met the inspectors on the day appeared happy and content in their homes. A number of staff spoke about the positive impact of recent recruitment and the establishment of core teams in the houses with the hope that this will lead to improvements in continuity of care for residents, communication within teams, and on teamwork. A number of staff vacancies remained however, although the provider was recruiting to fill them, as a result, there continues to be a reliance on agency staff to fill gaps in rosters.

There were also volunteer co-workers in the centre, and the inspectors met some of them who were present on the day. Inspectors were informed that co-workers were additional to the staffing quota and they did not appear on the roster. This system was under review again however, as some volunteer co-workers who live and sleep in the houses are named as resources in the event of a fire evacuation or emergency.

One house visited was home to four residents and on arrival an inspector observed residents relaxing over a cup of tea with staff. Warm and respectful interactions were observed between staff and residents. One resident helped to clear away the dishes and explained they liked to help in keeping their house tidy. This resident also explained to the inspector that they had a job that they enjoyed and liked to visit other towns nearby, explaining where they liked to go in particular.

In another unit there were no residents present while the inspector was visiting. Some were visiting family but others had jobs and had left for the day. All the residents in this unit lived in individual apartments and were independent when accessing the community. The staff on duty here explained that they were available for support and provided oversight in tasks that the residents identified as needing help with, for example, changing bed linen.

Two houses which made up this designated centre were located right beside one another on the outskirts of the town. At the time of this inspection one resident only used these houses who was met by an inspector in one of the houses. This resident appeared content and indicated to the inspector that they liked living in the centre, felt safe and liked the staff who supported them. While the inspector was present, this resident spent most of their time watching television in one of the houses although it was noted that they briefly left this house to put out some bins with the staff member supporting them. These two houses were reviewed by the inspector and were seen to be clean and well maintained at the time of inspection including the resident's bedroom.

Another house where only one resident lived was visited by an inspector. While the house was reasonably presented, the inspector did note some large cobwebs above the house's front door while some windows in the house required cleaning. The resident living in this house was met by the inspector and it was noted that this resident appeared very happy and comfortable with the staff member supporting them. While the inspector was present the resident talked about a recent holiday they had been on and was later seen to leave the house with a staff member to go to one of the other houses of the centre. Later on this resident was met by the inspector again with the resident again appearing happy. It was indicated to the inspector that the resident had earlier gone for a coffee with some other residents.

Two other houses were reviewed during this inspection. Normally one resident resided in each house but at the time of this inspection both residents were at home with their families. In general it was seen that these two houses were reasonably presented and efforts had been made to make them homelike. For example, in one house a specific area was set up for the resident to relax in which had items of interest to them while their bedroom was also personalised with photographs. It was noted though that in one of these houses a resident's bedroom was quite stuffy and needed some airing while in the other house, small garden areas to the front and rear of the houses clearly needed some grass cutting.

One of the larger houses visited by an inspector was noted to have two residents present. A third resident normally resided in this house but they were not present during the inspection. On arrival one resident was seated at the kitchen table using a laptop and some headphones to listen to some music. This resident greeted the inspector but otherwise did not engage with the inspector. The other resident present appeared shy around the inspector but seemed very comfortable with the staff members present. This resident had a particular communication style and the staff appeared very familiar with this. Residents' bedrooms in this house was seen to be brightly decorated and personalised although, while this house was generally well maintained, the inspector did note that the door frame into one of the bathrooms required maintenance. As the inspector was leaving this house, both residents were sitting at the kitchen table with one still using a laptop while the other was preparing to have a drink.

In summary, residents appeared comfortable and content in their homes. Some were regularly engaging in activities which they found meaningful and were aware of how to raise any concerns they may have, while others continue to be less

engaged. While some improvements were found during this inspection, there remained high levels of non compliance with the regulations.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Following a series of poor inspection findings in centres operated by Camphill Communities of Ireland throughout 2020, the registered provider was required to submit a comprehensive national improvement plan to the Chief Inspector of Social Services. As part of this national monitoring programme of Camphill Communities of Ireland this centre was most recently inspected in December 2020.

During this current inspection, the inspectors found that while there had been some improvements a number of these had only begun in the weeks that preceded the inspection. Therefore the sustainability of improvements had yet to be demonstrated which was also an area of concern as highlighted in the December 2020 inspection of this centre. While the centre was currently recruiting staff and inspectors acknowledge that a number of new staff had (or were about to) start work, the centre had been consistently under resourced since the last inspection. This was still impacting on the provider's ability to bring about some of the planned improvements in the designated centre.

It was evident during the inspection that the local management team were working on implementing actions from the providers' national governance plan and on embedding new practices in the centre. There had been two changes in the role of person in charge and in person participating in management since the last inspection in December 2020 and this had also again impacted on the effective implementation of consistent and sustained change.

Regulation 15: Staffing

Inspectors found that staffing numbers had increased since the last inspection and that this was leading to recent improvements in relation to continuity of care and support for residents. In recent months the provider had completed a detailed needs assessment for residents and had revised staffing levels that were required in the centre. The provider had successfully recruited for existing staffing posts and had reduced the vacant staffing complement from 19.1 whole time equivalent (WTE)

positions down to now a 2 WTE shortfall. Agency staff were used to cover the shortfall in staffing and they were clearly identified on the rosters, the provider had identified that for particular units where consistency was important, agency staff were not used. This was a noted improvement.

While inspectors acknowledge that the recruitment of staff was positive, the ability of the provider to retain staff was of concern. Alongside the recruitment of staff, the centre experienced a high staff turnover with staff on the ground talking about high numbers of staff leaving. The provider had self identified this as a concern and had risk assessed retention of staff as a medium rated risk. In one unit there is currently no staff cover at night and the provider has identified a need for sleepover staff cover and were in the process of trying to secure funding for this additional post.

One unit in the centre was unoccupied with the resident having been at home with their family during the COVID-19 pandemic, in order for them to return to the centre, their staff team needed to be recruited and this was also identified by the provider as a current deficit in staffing.

Inspectors reviewed a sample of personnel files and found that they contained the information required by Schedule 2 of the regulations. The provider had completed Schedule 2 audits since the last inspection and was picking up on areas for improvements and taking the required actions.

Judgment: Not compliant

Regulation 16: Training and staff development

On the day of inspection the inspectors were shown a training matrix that identified high numbers of staff requiring mandatory training or refresher training. When discussed with the provider during the day they reviewed the matrix and determined it to be incorrect. Changes in administration and in the local management team had led to administrative confusion with six or seven different trackers in the process of being amalgamated into one and this is reflected in the judgment regarding governance and management of the centre.

The provider requested an opportunity to show the inspectors the correct training matrix immediately following the inspection and this review was completed via an electronic meeting forum so inspectors could also cross reference with training certificates where required. This review demonstrated that three staff required fire safety refresher training that was scheduled, three staff required refresher training in manual handling. All other mandatory areas of training were in date for staff. A small number of staff who had just started were completing these training courses as part of their induction process.

Formal staff supervision was not being completed with staff as required by the providers policy. This was mainly due to there having been only one house co-ordinator in post instead of three until the two weeks before the inspection.

Inspectors noted that two co-ordinators were in post on the day of inspection with a third scheduled to start in the following few weeks. Some supervision had taken place and a review of a sample of these showed that staff were afforded the opportunity to raise any concerns they may have, particularly in relation to residents' care and support needs or in relation to how improvements could be made.

Judgment: Not compliant

Regulation 23: Governance and management

While improvements were noted in relation to the availability of some systems and templates, and while there was evidence of an increase in meetings and audits happening, the inspectors found that there remained gaps in relation to the monitoring and oversight of residents' care and support in the centre. As already mentioned above the provider and person in charge were working to streamline systems and to ensure localised systems were transferred to the providers new templates and were in line with updated policies. Improvements were found to be in their infancy and yet to fully impact on the the oversight and monitoring of care and support in the centre.

Inspectors requested documentation on arrival to the centre and again at intervals over the day, there was substantial delay in the local management team providing information to inspectors and this was reflective of concerns that a sustainable governance and management system was not yet in place in this designated centre.

A six monthly unannounced visit report had been completed in March 2021 and actions identified as being required. A plan had not been put in place to address any concerns identified in this at the time and as such the new person in charge was just beginning to review and prioritise actions that require completion. Management meetings were occurring regularly however house meetings had not been taking place on a consistent and regular basis.

During the December 2020 inspection of this centre inspectors reviewed an independent service review commissioned by the registered provider (October 2020) which had recommended the removal/closure of parts of the centre not deemed to be currently suitable to the assessed needs of residents. The actions identified by the provider as outlined in their compliance plan following this inspection included a commitment to submit an application to vary the living space and the sleeping quarters of one unit by 30/03/2021 and that the registered provider would apply to de-register the part of the designated centre deemed not appropriate for use. It was found that this had not yet been completed. The high level of non-compliance with the regulations that continues to be found in this centre along with the providers ongoing difficulties with consistent implementation of their systems was of concern to the inspectors.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose is an important governance document that outlines the nature of the service to be provided in the designated centre. While the statement of purpose contained most of the required information, some details such as resident numbers required greater clarity.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Inspectors reviewed a sample of incident reports in the centre and found that the Chief Inspector of Social Services had been notified of all those required by the regulations, within the specified timeframe.

Judgment: Compliant

Quality and safety

The provider was trying to ensure that residents were in receipt of a good quality and safe service. From what inspectors observed the residents lived in, for the most part, warm, clean and comfortable homes where efforts had been made to ensure they were personalised and homely. The provider was aware however, that not all of the units that make up this designated centre were to a high standard. The provider was aware that the premises all required some maintenance and painting with the internal layout in some houses requiring review to better meet current and future needs of residents.

Previous inspections of this centre had raised concerns around the management of residents' finances from a safeguarding perspective. During this inspection it was found that improved processes were in place with financial assessments having been carried out for residents. Systems were also in operation for financial transitions of residents to be recorded and reviewed. Inspectors reviewed a sample of such transitions and noted that the records in place corresponded with financial receipts kept and the money that residents had available at the time of inspection. It was noted though that some residents continue to not have full control over their own finances at the time of inspection which was not in keeping with the requirements of

the regulations.

In addition to systems for residents' finances, systems were also in operation for incidents and accidents occurring in this designated centre to be recorded and reviewed. Such systems should form part of a risk management process to help in the identification and review of any matters which could pose a risk to residents. In keeping with such a process, assessments were in place for identified risk which described the risk and outlined specific controls measures to reduce the potential for such risks to have a negative impact. However during this inspection it was found that improvement was required in the risk management process followed in the centre.

Relevant risk assessments were in place in this centre related to COVID-19 and during this inspection staff members were generally seen to use personal protective equipment (PPE) while each house had COVID-19 stations for hand washing and for visitors to the houses to sign in and out. Sufficient supplies of PPE and hand gels were also seen to be present. Since the December 2020 inspection, HIQA had not been notified of any confirmed case of COVID-19 associated with this centre. However, during the current inspection improvements were identified regarding the infection prevention and control practices as outlined below.

Gaps were also noted in the internal fire safety checks that were being carried out by staff in the centre also. Such checks are important to ensure that the fire safety systems in place are working effectively and when reviewing the internal checks that had been carried out by staff it was noted that they did not raise any issues regarding the fire doors that were in use in the centre's houses. Such fire doors are important to prevent the spread of fire and smoke in the event that a fire occurs but despite the checks that had been carried out, during this inspection it was observed that some fire doors were not operating as intended. For example, some doors had a noticeable gap under them where smoke could pass through while others were not closing fully which reduced their effectiveness.

Regulation 12: Personal possessions

Inspectors reviewed the systems for residents to access and retain control of their personal property and possessions and found that the updated policies, procedures and practices relating to finances and personal possessions in the organisation were for the most part protecting residents.

Residents had financial assessments in place and were being supported to manage their finances. Where residents had control and access to their own finances in keeping with the requirements of the regulations then records of residents' income and expenditure were maintained and were being regularly audited. Where residents have been assessed as being independent in the management of their finances then the provider has put a transparent system of support in place around the reconciliation of statements with residents. A number of residents however, remain in a position where they do not have full control of their finances and the provider

therefore is not in a position to assure financial safeguards are in place.

Judgment: Substantially compliant

Regulation 17: Premises

Not all units in this designated centre were presented to the same standard which the registered provider has self-identified. Inspectors were shown proposals for refurbishment and changes to current layout of properties which were required to meet assessed needs of residents. All residents have access to their own bedrooms and had access to communal spaces within the house if required.

One house had been noted to have experienced flooding in February 2021 and the staff team utilised sandbags to prevent water from entering the residents home. Other houses required maintenance and decoration, in one house the inspectors noted that showers above the baths were not fitted to the walls as fixtures were broken and in another house the grass had not been cut either to the front or rear of the property. Where residents were not currently present their rooms required airing or in some cases cleaning.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had risk management policies, procedures and practices in the centre however, improvement was required in the risk management process followed.

For one resident it was seen that specific risk assessments had not been reviewed since July 2020 despite a number of relevant incidents involving this resident having taken place in 2021. A risk assessment in place for another resident indicated that knives were to be stored in an area away from the resident as a control measure but during the inspection it was observed that such knives were freely available for the resident to access. It was also noted that an incident had occurred in one house in the months leading up to this inspection where the fire brigade was called. Those involved in the management of this centre were unaware of this incident although it was acknowledged that some of these had only taken up their positions since this incident occurred. However risk knowledge and awareness should have been better.

Judgment: Not compliant

Regulation 27: Protection against infection

Residents were for the most part protected by the policies, procedures and practices relating to infection prevention and control in the centre. Some improvements were required however. For example, inspectors noted that while COVID-19 stations were generally in place right at a specific entry/exit point for the houses, in one house it was seen that the COVID-19 station was located in the kitchen rather than at the designated entry/exit point where space was available for the station to be present. In another house a staff member was seen to enter and exit the house without wearing a face mask nor signing the visiting log in place for the centre.

The houses were found to be mostly clean however, as already stated some areas required cleaning such as bedrooms currently not occupied. Review of the cleaning schedules noted that there were gaps in recording for both daily cleaning and deep cleaning. Where the provider had systems in place to protect residents from the risks associated with water borne disease such as Legionnaires disease there were also gaps noted against the checks and systems in place.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had a range of fire precautions in place in the centre however, improvements were required in order to ensure an efficient fire safety regime was in place.

Fire safety systems were in place throughout the houses of this centre which included fire alarms, emergency lighting and firefighting equipment such as fire extinguishers and fire blankets. It is important that such systems receive maintenance checks to ensure that they are in proper working order and it was seen that the fire extinguishers had received their annual maintenance check by an external contractor in February 2021. Fire alarms and emergency lighting should receive similar checks on a quarterly basis and while these had both been serviced in March 2021, the fire alarms and emergency lighting in the houses of this designated centre were overdue another quarterly maintenance check at the time of this inspection.

Fire doors were in place throughout the centre however, as outlined above they were found to not be operating as intended and some doors presented with noticeable gaps around the edges of the doors and did not therefore create an effective seal to prevent smoke and fire from moving through the centre. Internal staff checks on the fire safety systems were inconsistent and did not identify the issues identified on this inspection relating to fire doors.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Inspectors found that there was some oversight of positive behaviour support in the centre. However, for some residents there were a number of versions of plans in place all of which outlined supports to be available to residents. These documents had not all been developed or reviewed by the relevant professionals. In addition, the variation in plans and lack of amalgamation and review led to an absence of clear guidance in place for staff when supporting residents.

There were a number of restrictive practices in place and these were being reviewed regularly to ensure the least restrictive practices were used for the shortest duration. There was evidence that some restrictions had been introduced to manage a specific incident and were then subsequently reviewed and reduced in consultation with a resident.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had revised their safeguarding policy and had taken action to better identify safeguarding issues and to record and report them. There were six safeguarding plans in place in the centre on the day of inspection and evidence that substantive work had been completed by the provider in reviewing or closing plans as required. There was evidence that actions had been taken and control measures were in place to keep residents safe. One previous plan that had been closed by the provider was reopened following review by an external agency and currently was under further review as it pertained to current residents.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Carrick on Suir Camphill Community OSV-0003608

Inspection ID: MON-0032378

Date of inspection: 17/08/2021

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: Camphill Carrick continues to recruit to the allocated WTE required to ensure safe and effective care. Carrick completed a recruitment drive in August and September and the new hires currently being onboarded will significant dependency on agency. A robust recruitment system is in place through Ocupop that allows for full review of all candidates, this allows for circulation to all major job vacancy sites.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training and development remain an area of priority, discussion and review within the Community Managers Meetings and individual supervision. All scheduled training and supervision has been completed and the training and supervision trackers will be reviewed monthly by the PIC/Admin.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We have successfully appointed the full-time Person in Charge within Camphill Carrick since 26/07/2021. The newly appointed PPIM also started end of July and remains working closely with the new person in charge and is on site once weekly reviewing the ensuring the actions outlined in previous and current audits are followed up. A new Quality and safety Coordinator has started in post on 10.09.2021. The new Person in Charge alongside the PPIM are ensuring the full implementation of all Camphill Communities of Irelands policies and procedures.

The following auditing tools have been introduced in line with National Policy and Procedure and standardized national templates to review the following areas
-Residents finances
-Medication
-Care files
-Health and safety
-Daily logs and other care logs
These are reviewed with PIC and discussed within Management meetings. Findings lead to action plan being created and then implemented and discussed within the team.

The provider is actively working in partnership with the HSE to address the resource gaps at the center both on a local and national level. CcoI have invested in a Quality Management system, prioritizing the audit, risk and incident modules of the system.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose is curently being updated, to reflect current changes at community level and will be submtted as part of the re registration suite of documents by 29th October 2021. All required information wil be included.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The person in charge is working with all families for implementation of financial policy for

each resident. Letters have been provided to families to support understanding and ensure the governance of our CMSN's monies at all times.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Areas which required cleaning on the day of the inspection Bedroom were completed that day and inspected by the PIC. Part of the designated centre which has been unoccupied for a period of time has had a deep clean completed by and external contractor. A regular cleaning schedule has now been put in place. PIC has also introduced an environmental walk around informal daily and formal weekly and with actions being assigned accordingly.

Maintenance works have been escalated through the online system and routine maintenance has been prioritized and scheduled. The provider is actively working in partnership with the HSE to address the resource gaps at the center both on a local and national level.

It is our intention deregister and close part of the designated centre and an interim short-term accommodation plan has been identified and transition plans have been created to support the move of CMSN's by the 29th of October 2021 to more appropriate accommodation.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A comprehensive review of all risk assessments has been completed, any changes or updates have been reviewed and are discussed within the management meetings to guide and support staff at house level.

Risk assessments are currently a permanent feature within House meetings to ensure the staff carry the knowledge and understanding of managing and reducing risks.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
All staff have been retrained in our Covid SOP's. This has assured the appropriate use of face masks and that the appropriate face mask is used in line with recommendations.

Cleaning schedules are in place for all houses in the community to ensure all rooms are deep cleaned once a week, wash stations are cleaned and monitored on an hourly basis each day. A weekly environmental walk is carried out by the house coordinators. Also a visual inspection is carried out by the PIC.

Cleaning schedules are reviewed weekly to ensure consistent oversight and maintenance of records

A stock of PPE is available in Carrick for the community as required.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A fire door inspection survey was carried out by an external contractor 7/09/2021 for all premises. A report has identified the remedial works required and resources have been sought for these essential works.

Regular checks of the fire register remain in place to ensure the consistent completion of the daily and weekly checks on fire safety. This is audited regularly by the PIC

A night time fire drill took place in all houses in line with schedule and any actions were completed accordlingly.

External certification of the fire alarms and emergency lighting system was completed on 31st August and certs provided. A schedule has been developed for the remainder of the year and provided to contractor (October 18th/19th for Q3 and also December 13th/14th for Q4)

Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Additional training and support was provided to staff 24/9/21 to ensure clear gudiance and support for staff. All PBSP's have been reviewed, old material has been archived to ensure staff are guided by the relevant and current plan. The House Meeting agenda will contain a review of all PBSP's to support and guide staff All restrictive practices were reviewed and updated since inspection.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/12/2021
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.	Substantially Compliant	Yellow	31/12/2021
Regulation 15(3)	The registered provider shall	Not Compliant	Orange	31/12/2021

	ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
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	01/12/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/11/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/03/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/01/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out	Not Compliant	Orange	01/11/2021

	in Schedule 6.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/12/2021
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	01/11/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Not Compliant	Orange	01/12/2021

	ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	01/11/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	01/12/2021
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	01/10/2021
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	01/10/2021
Regulation 28(3)(a)	The registered provider shall make adequate	Not Compliant	Orange	01/10/2021

	arrangements for detecting, containing and extinguishing fires.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	03/11/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	01/11/2021