Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	The Bridge Community
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Short Notice Announced
Date of inspection:	11 February 2021
Centre ID:	OSV-0003605
Fieldwork ID:	MON-0031807

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Thursday 11 February 2021	09:30hrs to 16:30hrs	Marie Byrne	Lead
Thursday 11 February 2021	09:30hrs to 16:30hrs	Erin Clarke	Support

What residents told us and what inspectors observed

From what residents told the inspectors, from what they wrote in their questionnaires and from what the inspectors observed, it was evident that efforts were being made to ensure that residents were in receipt of a good quality and safe service. Residents appeared happy and content in their home and the inspectors observed kind, caring and respectful interactions between residents and staff during the inspection. There was a clear focus in the designated centre on ensuring residents were empowered to have control over, and make decisions in relation to their day-to-day lives. The provider was in the process of implementing a number of actions from the previous inspection and their national improvement plan, and these actions were starting to have a positive impact on the lived experience of residents in the centre. However, the centre remained under-resourced and improvements were still required in relation to staffing numbers, the monitoring and oversight of care and support for residents, and documentation in the centre. These will be discussed in greater detail later in this report.

There were fourteen residents living in the designated centre on the day of the inspection, and the inspectors had the opportunity to meet with four residents over the course of the inspection. In addition, eight residents completed or were supported by staff to complete a residents' questionnaire prior to the inspection. Feedback from residents was mostly positive in relation to their care and support and a number of residents clearly stated that they were very happy living in the centre. Some areas for improvement were identified by residents and these included, support for them to go on holidays, their access to activities particularly community based activities, and staffing support. A number of residents described the impact of the COVID-19 pandemic on their day-to-day lives. They particularly described the impact it was having on their access to activities and on spending time with their families and friends.

This inspection took place during the COVID-19 pandemic and as such the inspectors adhered to national best practice and guidance with respect to infection prevention and control. The inspectors reviewed documentation in an office location and visited two of the five houses in the designated centre (one house each) over the course of the inspection.

Of the five houses which made up the designated centre, three were on a site which also included a weavery, craft and coffee shop, a bakery and catering workshop, and organic fruit and vegetable retail outlet, a hall, a farm, a picnic area, vegetable gardens, a duck pond, a nature trail and a wildlife area beside a river. The other two houses were in the local community. As previously mentioned, the inspectors visited two houses, and these were both on the main site. Both of these houses were found to be homely and residents either told the inspectors or indicated in their questionnaires that they were happy with how comfortable they were in their home.

Residents were observed coming and going around the farm and grounds during the day and to enjoy spending time in their preferred outdoor spaces. Throughout the inspection, they appeared content and comfortable on the campus and in their home. They also appeared comfortable with the levels of support offered by staff. Residents meetings were occurring regularly with discussions relating to menu planning, activities, and the day-to-day running of their homes.

In one of the houses, the inspector had the opportunity to meet two residents. One resident was relaxing in their bedroom and invited the inspector and a staff member in for a chat. They talked to the staff member and the inspector about how long they had been living in the centre and what it was like to live there. Overall, they were complimentary towards the staff team and how they supported them every day. They talked about what they would so if they had any concerns and described how they would ring any of the staff team if at any time they did not feel comfortable or safe in their home. They described food in the centre as good and told the inspector about how many choices they had and how decisions were made in relation to what was on the menu. They talked about their roles and responsibilities in their home and about how they liked to chair residents' meetings.

Another resident who had been out working around the grounds for the morning, came into the house in the afternoon to show the inspector around their home, before going back out to do some more work. They showed the inspector pictures which were important to them and their television and armchair in their bedroom for relaxing in when they were finished work. This resident appeared very comfortable with staff and staff were observed to be familiar with their preferred communication style. Staff were observed to listen to them, and to pick up on their communication cues.

In another house, the inspector had the opportunity to meet three residents who lived there. One resident was making tea in the kitchen and they were laughing with staff and the person in charge. They spoke of the impact that COVID-19 had on their life and how they were happy that a vaccine would soon be made available to all residents. They spoke of the plans they were making to travel once the pandemic was over. Another resident was resting and did not want to meet with the inspector at that time. The inspector observed staff and residents interacting with each other, and found that residents appeared comfortable expressing their needs, and were directing the care and support they received. For example, a resident was asked where they would like to sit and were supported with this.

Residents indicated in the questionnaires they completed prior to the inspection, that they had been living in the centre for between 5 and 23 years. They indicated that for the most part, they were happy with the comfort levels and access to shared areas in the centre, their bedrooms, food and mealtimes, choices, privacy and respect, and their safety. The majority of residents indicated they were happy with the choice and control they had in their life and a number of residents included comments about how happy they were to be living in the centre.

Residents also indicated that they were aware of the complaints process with some who had used the process indicating they were happy with how their complaints

were dealt with. From a sample of residents' complaints reviewed, it was evident that they were being followed up on. If the matter could not be resolved locally, it was being escalated to the complaints officer and the management team. Residents' levels of satisfaction with the outcome of their complaints was being recorded.

In their questionnaires, residents described a variety of activities they liked taking part in either in their home or in their community. These included, going for a walk, gardening, going on holidays, watching movies, listening to music, going to parties in the local community, going to the golf club, doing a computer training course, going to work, going to the pub or coffee shop, baking and cooking, swimming, and horse riding. One resident also included some of their goals for the future such as, " I want to explore places around the world" and I would like to "find out more about other people and how they live".

While speaking with inspectors and in their questionnaires, residents were complimentary towards the staff team. Residents included the following statements about staff in their questionnaires, they are "very good at supporting me", "I like them all", they are "nice", they are "fine", and "they are good to me, I like them". However, the lack of permanent staff and the impact of this on residents' care and support was detailed in some residents' questionnaires, in a sample of complaints by residents or their representatives viewed, and in residents' representatives views in the six monthly visit by the provider. The provider was aware of this and details relating to the actions they were taking to address this will be detailed later in this report.

Other areas of improvement detailed by residents in their questionnaires included a number of residents stating they were unhappy with their access to activities particularly those in their local community. One resident indicated they would like a new bed, and another resident indicated they would like their favourite foods more regularly.

Residents and their representatives' views had been captured as part of the six monthly visit by the provider in June 2020. In this review, eight residents views and five residents' representatives views were captured. Feedback was mostly positive with residents' representatives indicating that they felt included and were being kept informed in relation to their relatives' care and support in the centre. They indicated they knew who to contact if they had any concerns, with one person commenting that they found that local managers were available to them and approachable. Two residents' representatives noted that the significant support that volunteers brought to their family member and were particularly complimentary towards their availability to spend time with their relative engaging in social activities, to support them with their hobbies and in creating a homely atmosphere in their home.

One residents' representative said that they were finding it difficult to ensure consistency of staff in the centre and that they would like to see more social engagements between residents and staff. Another residents' representative voiced concerns in relation to the turnover of staff in the preceding 18 months.

Residents' views captured in this six monthly review, identified a number of areas where they would like to see improvements in relation to their care and support in the centre. A number of them referred to the impact of the COVID-19 pandemic on their access to social and family contacts. For example, they were missing going to the coffee shop, going to work and visiting friends and family. Residents also raised concerns in relation to the inability of the organisation to support them to go on holidays with the support of staff annually. There was an accessible complaints form available for residents and the inspector viewed a sample of residents complaints and concerns. Two of these reviewed related to residents not being happy to sign their new contract of care due to the changes relating to going on holidays. In addition to raising this as complaints, residents had brought this to their advocacy group. They were working with the provider at the time of the inspection to resolve this. One resident also raised a complaint in respect of a staff member, the staff member has since left the centre and this residents' experience has led to important learning. The resident was happy the staff member was no longer working there.

In summary, for the most part residents were being supported to be happy and safe in their home and to have their basic care needs met. They were being supported to make choices and have control over how they wished to spend their day, in as far as this was possible due to the current levels of restrictions relating to COVID-19. Residents had good things to say about what it was like to live in the designated centre, but they also identified areas where they would like to see improvements. A number of residents had used the complaint's process to voice their concerns and there was evidence that these were being followed up on by the provider.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

Following a series of very poor inspection findings in centres operated by Camphill Communities of Ireland in 2020, the registered provider was required to submit a comprehensive national improvement plan by the Chief Inspector of Social Services. Due to the levels of concern found, substantive provider led improvements were required across all Camphill Communities of Ireland designated centres. This national improvement plan was submitted by Camphill Communities of Ireland in October 2020. Due to the seriousness of the regulatory concerns regarding both the capacity and capability of the registered provider and the quality and safety of care and support delivered to residents, the implementation of this national plan is being monitored by the Chief Inspector on a monthly basis. This inspection formed part of this national monitoring programme of Camphill Communities of Ireland.

This risk based inspection was also completed as a result of concerns relating to the governance and management arrangements in the centre as the Chief Inspector had

become aware of a number of staff resignations and changes in relation to the local management team in the designated centre.

Overall the findings of this inspection were that improvements were noted across an number of regulations reviewed on this inspection. However, the centre remained under-resourced and this was found to be impacting on the provider's ability to bring about some of the planned improvements in the designated centre.
The inspectors found that changes made by the provider in this centre were in their infancy and yet to fully impact on the safety, quality and standard of care delivery for residents.

Overall, residents appeared to be happy and content in their homes. For those who had concerns, there was evidence that they were discussing them with the local management team and escalating their concerns via the complaints process. Improvements were evident since the last inspection in relation to continuity of care and support for residents, staff training, the frequency of staff and management meetings, the oversight and maintenance of residents' financial records, the review of residents' contracts of care, and infection prevention and control. Although improvements were noted in relation to these areas, improvements were still required and issues relating to staffing numbers and the day-to-day oversight and monitoring in the centre remained of particular concern.

The person in charge who was on leave at the time of the last inspection in August 2020, had since resigned their post. Following this, the provider had put interim arrangements in place while they recruited to fill the person in charge post. The provider had notified the Chief Inspector that they had employed a person to fulfill this role in December 2020. However, the documents required under the regulations had not been submitted by the provider within the timeframe specified in the regulations. As a result a decision could not be made in relation to their fitness to fulfill the role in line with the requirements of the regulations. While requesting an update in relation to this required documentation, the Chief Inspector became aware that this person had resigned their post in January 2021. In addition, a house co-ordinator and an administrative staff had resigned their posts in January 2021.

At the time of this inspection, the provider had identified a new person in charge who had commenced in their role on 01 February 2021 and the Chief Inspector was notified of their appointment on the day of the inspection. The documentation required by the regulations for the person in charge were outstanding at the time of this inspection. A new person participating in the management of the designated centre (PPIM) had been appointed and had commenced in post on 08 February 2021. The Chief Inspector was notified of this change on the day of the inspection and the provider was in the process of submitting the required documentation.

This inspection was facilitated by the quality and safety co-ordinator who had been responsible for the day-to-day management of the centre at intervals since the last inspection. They were found to be knowledgeable in relation to residents' needs and preferences and motivated to ensure they were happy and safe in their home. The newly appointed person in charge and regional manager was also present on the day of inspection. They were aware of the of the provider's national

improvement programme and of the areas for improvement required in the centre and motivated to bring about the required changed to ensure residents were in receipt of a good quality and safe service.

The systems in place to ensure monitoring and oversight of care and support for residents continued to require improvement. Whilst it was evident that efforts had been made since the last inspection to bring about the required changes to improve oversight and monitoring in the centre, the changes in the management team during this time had impacted on the availability of key staff to implement these plans. Areas where improvements were evident, related to the frequency of meetings in the designated centre. For example, weekly meetings were occurring in the houses, fortnightly local management meetings and monthly senior management meetings were also occurring in line with provider's national improvement programme. However, regular audits and oversight were not evident. For example, themed audits were not being completed in the houses, as planned. There was an audit schedule in place for 2021 with plans for regular audits of residents' care and support needs and some audits relating to the day-to-day management of the centre.

The provider had not completed an unannounced six monthly review since the last inspection, in line with the timeframe identified in the regulations. There was an annual review of the quality and safety of care, however there was limited evidence of follow up or completion of some of the actions from this review. Following the last inspection, the provider had identified 60 actions to bring about the required improvements. At the time of this inspection, 47 of these actions had been completed and 13 were in progress, despite the timeframe identified by the provider for completion of all of the actions, having passed.

In line with the findings of previous inspections, the provider was aware that there were insufficient numbers of staff to meet the number and needs of residents in the centre. They remained in the process of completing dependency needs assessments and a roster review to support a business case to the Health Service Executive (HSE) for additional resources. Before completion of these dependency needs assessments and roster reviews, the provider had identified in their statement of purpose, that the whole time equivalent staff requirement in the centre was 25 whole time equivalents (WTE). There were 19 WTE staff working in the centre at the time of the inspection and the provider had advertised to fill the six vacant posts.

There was evidence of improvements in relation to the continuity of care and support for residents since that last inspection. There were now core teams of staff identified for each of the houses in the designated centre, and there were three regular agency staff and four regular relief staff working in the centre. Volunteers were living in a number of the houses and being utilised as 'supplementary support' in the centre. Their roles and responsibilities were clearly documented and they were not individually accountable for direct care and support for residents. A sample of staff and volunteers files reviewed contained the majority of information required

by regulations. However, from the sample reviewed a number of them contained gaps in staff's employment histories.

Improvements were also noted in relation to staff's access to training and refresher training. However, a number of staff required some refresher trainings. The provider had implemented a new system to record training, identify training gaps and for ensuring staff were booked onto the required courses. A learning and development officer had just commenced in post. There was a supervision schedule in place to ensure staff were in receipt of regular formal supervision in 2021. The inspectors reviewed a sample of staff supervision and found that staff's roles and responsibilities in relation to residents' care and support were being discussed.

The provider had prepared a new contract of care for each resident and held several stakeholder meetings to review the provision agreement in line with the admissions process and statement of purpose. An accessible version was available that clearly laid out the changes between the two contracts. Inspectors found this enabled residents to provide informed feedback on the changes. This was exercised through the residents' weekly meetings. Whereby residents were not happy with the decision to remove the choice to go on a holiday with staff and highlighted the need for the provider to review this decision. Some improvements were required to amalgamate the old contracts, new contracts and schedule of fees. The contribution to be paid by each resident was not clearly laid out, and not all the contracts had the fees to be incurred outlined in them.

Registration Regulation 7: Changes to information supplied for registration purposes

The provider had failed to submit the required documentation for the person they appointed as person in charge, in line with the timeframe identified in the regulations.

Judgment: Not compliant

Regulation 15: Staffing

There were six staff vacancies at the time of this inspection which equated to 24% of the required staffing in the centre. The provider had advertised to fill these positions at the time of the inspection. In addition to these vacancies, and in line with the findings of previous inspections, the provider was in the process of working with the Health Service Executive (HSE) to complete a review of staffing numbers in the designated centre to ensure they could meet the number and changing needs of residents living in the designated centre.

A sample of schedule 2 files were reviewed and found to contain the majority of information required by the regulations. However, a number of staff files did

not contain a full employment history, as there were a number of gaps in employment with no explanation offered.

Judgment: Not compliant

Regulation 16: Training and staff development

Eight staff were due refresher training such as manual handling, fire marshall and managing behaviour that challenges training and they were booked onto these training courses in 2021.

Two staff were overdue epilepsy rescue medication training. They were due to complete this training in 2020, but were booked onto it in March and June of 2021. The inspectors were assured that until these two staff members had completed the training, that they would work with staff who had this training completed.

Judgment: Substantially compliant

Regulation 21: Records

The inspectors found that a number of documents viewed during the inspection were not being reviewed and updated as required. For example, the risk register contained information relating to another designated centre, there was limited evidence of follow up and completion of actions relating to some audits in the centre and the inspectors were told by staff about fire drills which had occurred in the centre, but there was no documentary evidence that these had occurred.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had completed the majority of actions identified by them following the last inspection. However, a number remained outstanding despite the timeframe for completion of these actions having passed. Examples of the outstanding actions included, a review of residents' money management assessments and plans, a review of residents' intimate care plans, and the recruitment to fill staffing vacancies.

A number of audits were being completed as planned, such as themed audits which were due in each of the houses. There had been a small number of audits completed since the last inspection. There was also limited evidence of follow up or

the completion of actions relating to some of the audits and reviews completed by the provider. The inspectors acknowledge that there had been a number of infection prevention and control audits completed since the last inspection.

The provider had not completed a six monthly review of care and support in the centre in line with the timeframe identified in the regulations.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

A sample of contracts for the provision of services were reviewed and it was noted that they did not not accurately set out the fees to be charged.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed and updated in line with the requirement of the regulations. There was some information which required updating at the time of the inspection, and the provider updated this during the inspection. The statement of purpose now contained the information required by the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector was not given notice in writing within three working days of all allegations or suspicions of abuse of any resident in line with the requirements of the regulations. Six notifications were notified later than the required timeframe between September 2020 and the day of this inspection.

Judgment: Not compliant

Quality and safety

The provider and person in charge were striving to ensure that residents were in receipt of a good quality and safe service. Residents were being supported to make choices and in as far as possible during the pandemic, to engage in meaningful activities. From what the inspectors observed when visiting two of the premises, residents lived in a clean, warm and comfortable home. However, as previously mentioned, improvements were required in relation to the monitoring and oversight of care and support for residents, the review and update of some documentation in the centre, staffing numbers, residents' financial management and access to their finances, positive behaviour support and safeguarding.

The premises visited during the inspection were warm, clean, comfortable and kept in a good state of repair. Each resident had their own bedroom which was decorated in line with their wishes and preferences. The premises was designed and laid out to meet the number and needs of residents. Their home was accessible, safe and homely. The design of the premises was such that it enabled the promotion of independence and provided spaces for residents to take part in recreation and leisure. There were facilities for residents to cook and bake should they so wish and they had access to laundry facilities and sufficient storage for their personal possessions.

As previously mentioned, during the inspection, both premises visited were found to be clean. There were cleaning schedules in place, which had been adapted in line with COVID-19 to ensure that each area of the house was regularly cleaned, including regular touch point cleaning. Information was available for residents and staff in relation to COVID-19 and infection prevention and control. The provider had developed or updated existing policies, procedures, and guidelines and they had developed contingency plans for use during the pandemic. There were systems to ensure there were adequate supplies of personal protective equipment (PPE) at all times. Residents were aware of measures to take during the pandemic. For example, residents were observed to maintain social distancing during interactions with staff and the inspectors, and one resident asked an inspector if they had washed their hands on the way into their home and whether they would wash them again on their way out. Staff were observed to wear masks throughout the inspection. There were sufficient handwashing facilities available and systems to ensure residents, staff and visitors were checking their temperatures regularly.

Inspectors were aware prior to inspection that there was a change in some residents' assessed needs through the reporting of safeguarding notifications as required by the regulations. On review of the systems in place and supports available to positively address behaviours of concern, inspectors noted that the provider failed to implement a clear referral pathway for residents to access positive behavioural supports in a timely manner. While some residents had a behaviour support plan to guide staff on how best to support their assessed needs, it was not subject to a suitably professional review. Trending of notifications indicated an increase of incidents over a six-month period; therefore, the behaviour support plan reviewed by inspectors did not effectively support residents in managing their behaviour. Due to the complex nature of some of the residents' support needs, a consistent and professional approach to behavioural support was required.

There were policies and supporting procedures for ensuring that residents were protected from all forms of abuse. Residents told the inspectors that they felt safe in their homes. Residents were supported by staff to develop their knowledge, self-awareness and understanding of safeguarding through keyworking sessions and weekly residents' meetings promoting safeguarding information. Staff facilitated a supportive environment which enabled the residents to feel safe and raise any safeguarding concerns that they may have. As discussed above, it was not evident that all safeguarding plans were fully effective as some similar allegations continued to be reported.

Staff and management were found to have promoted a restriction-free environment for residents so that best practice and the resident's rights and dignity prevailed. For example, the quality and safety co-ordinator had contacted a regulated financial institution to address residents' financial and economic opportunity needs proactively. Limitations that had been placed upon residents' banking accounts at the time of being set up and were queried to ensure these were applied with a clear and fair rationale. As a result, residents' individual needs and preferences to have access to and manage their financial affairs were promoted.

Inspectors found that areas for improvement identified during the previous inspection regarding the recording of restrictive practices had improved. Systems were in place for the review of restrictive practices, and as the result of the last inspection, the provider had introduced a restraint register. On review of the restraint register, there was a low level of environmental restrictive practices in place; these were required to ensure resident safety. There was evidence that these practices were implemented with the informed consent of the resident or their representative. Inspectors found during the inspection that residents had free and unobstructed access to their homes and grounds.

Inspectors reviewed the systems for residents to access and retain control of their personal property and possessions. The registered provider had submitted an improvement plan addressing this area due to non-compliances identified during inspections at a national level. The inspectors viewed a sample of residents' daily finances and found that record balances accurately reflected receipts and outgoings. Clear documentation was maintained by staff of expenditure made by residents, and this was checked and signed off by management on a monthly basis. The inspectors noted that the majority of residents had money management assessments completed; however, a number were outstanding at the time of the inspection. The provider had engaged in lengthy consultation with residents and their representatives to ensure they had adequate oversight of residents' monies.

This was still ongoing at the time of the inspection, so not every resident had access to and control over their money and support to manage their financial affairs. However, inspectors acknowledged that the provider had migrated the risk of lack of financial oversight by requesting access to bank statements that were reviewed as part of the monthly checks to ensure that outgoings were verified and accurate. An area of improvement that the provider had implemented was the development of an

asset register to log residents' personal belongings to ensure that residents retained control of their personal property.

The inspectors found that efforts were being made to promote the health and safety of residents living there. The risk management policy in place had been reviewed since the previous inspection and outlined the measures and actions to control specified risks that met the regulations' requirements. An up-to-date risk register was in place, and each resident, where required, had individual risk assessments in place to promote their quality of life and protect them from harm. Inspectors found that improvements were needed to the risk register to ensure that the document was centre specific and referred only to the designated centre's risks.

The registered provider had ensured that adequate fire safety management systems were in place. Suitable fire equipment was provided and serviced when required as maintained in the fire record folder. Inspectors observed precautions such as magnet releases for fire doors in high-risk areas to enhance fire containment measures as required by residents' assessed needs. Fire exits were found to be clear of any obstructions at the time of the inspection. The inspectors found that a number of fire drills had been carried out; however, improvement was needed, especially with the night time stimulated drills, to demonstrate that all residents could be evacuated promptly any time of the day. The record keeping of such drills was not effective at evidencing which residents took in a drill, how many staff supported residents and what scenario was used in the drill. Another key area that required improvement was ensuring that residents' personal emergency evacuation plans were updated (PEEPs) with any learning gained following the drills.

Regulation 12: Personal possessions

The providers plans regarding residents' financial management and access to finances was not fully completed at the time of the inspection. However, there was evidence of improvements since the previous inspection. Plans to support each resident to complete financial assessments to ensure they had control over their money and the required supports to manage their financial affairs were progressing. Seven assessments had been completed at the time of the inspection and the remaining five were due to be completed by the end of February 2021.

Judgment: Not compliant

Regulation 17: Premises

The premises visited during the inspection were designed and laid out to meet the number and needs of residents living there. They were found to be clean and kept in a good state of repair. A number of residents showed the inspectors around areas

of their home and were observed to appear comfortable and happy in their home. In addition, residents were complimentary towards their home in their questionnaires.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspectors found that the systems in place in the designated centre for the assessment, management and ongoing review of risk were satisfactory. The risk management policy included all required elements as outlined in the regulations. A centre wide risk register was in place along with risk assessments relating to individual residents.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had policies and procedures in place in relation to infection prevention and control. Staff had completed hand hygiene, infection control and PPE training.

They provider had developed and adapted existing policies and procedures to guide staff practice during the COVID-19 pandemic.

The premises visited during the inspection were clean and there were cleaning schedules in place to ensure all areas of the house were regularly cleaned.

There were supplies of PPE available and systems in place to ensure there were adequate stocks available.

Judgment: Compliant

Regulation 28: Fire precautions

Improvements were required in the area of fire evacuation procedures, specifically fire drills that simulated night-time staffing arrangements in the centre and the learning from these drills.

From reviewing records of the drills it was not demonstrated what supports were given to certain residents to ensure that they safely evacuated the centre in a timely manner.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where behaviours of concern were identified these were not always supported by a plan of care to ensure that consistency of care was provided to the resident.

The behavioural support interventions required by residents were not adequately or consistently provided for.

Judgment: Not compliant

Regulation 8: Protection

There had been an increase in the number of allegations of abuse in the centre and it was not evident that the safeguarding plans and control measures in place were fully effective as a small number of allegations of abuse continued to occur.

Not all residents' intimate care plans were updated to ensure that each resident's dignity, safety and welfare was guaranteed.

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	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for The Bridge Community OSV-0003605

Inspection ID: MON-0031807

Date of inspection: 11/02/2021

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**
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: - NF30A was submitted on the 09th of February 2021, all required documentation has been uploaded to the portal and an interview has part of the fitness assessment for new PIC has been scheduled for Monday 15th of March 2021.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: - One position (House Co-Ordinator) has been filled since inspection and has come in to post since 09/03/2021. - Other vacant positions were advertised at time of inspection. Recruitment is still ongoing and positions remain advertised. - Needs assessment and resource allocation analysis using SUIT tool to determine WTE for service has been completed to capture changing need of community members with support needs. In line with findings business cases to be pursued with HSE. - Internal Schedule 2 audit tool updated to include addressing gaps in CV. PIC will review all schedule 2 documents prior to hiring any staff. - Hiring process reviewed and updated to include requirement of staff to document reasons for any gaps in CV.	

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
- Additional Buccal Midazolam training was brought forward and was conducted on February 22nd 2021.
- As observed on inspection Manual Handling scheduled for 24/03/2021 and Fire Marshall training is scheduled for the 23/03/2021.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
- Risk Register was updated on February 16th 2021 at meeting which was scheduled prior to inspection.
- Fire drill form updated and reviewed on the 19/03/2021 with staff teams to ensure sufficient information was gathered during fire drill process.
- Schedule for fire drills set and notified to each team with email reminders on 22/02/2021.
- Fire drills reviewed at weekly team meetings following drills and actions distributed and followed up on.
- Audit schedule in place for 2021 including weekly walkarounds to ensure documentation is in place and actions are being followed up on.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
- Local compliance plan updated to ensure all outstanding actions are included.
- Actions reviewed at PIC monthly supervision with Regional Manager.

- Audit schedule in place for 2021 to ensure documentation is in place and actions are being followed up on.

- A national schedule for the six-monthly Regulation 23 Unannounced inspection

schedule in place. The Inspection is scheduled and will be completed by the end of March 2021. The schedule going forward will ensure that we are within the required timeframe of six months.

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

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The contracts and associated schedule of fees for each CMSNs will be reviewed and audited by 30/04/2021 to ensure all charges accurately reflect the fees that apply. Where corrections are required this information will be shared with CMSN in an easy read version and an amended schedule of fees will be re-issued.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
- Hiring of new PIC allows for the quality and safety lead to focus solely on this position and have greater time to dedicate to designated officer role and ensure notifications are submitted on time.
- Teams meeting took place on Monday 08/03/2021 with Regional Manager, Person in Charge and Quality and Safety to discuss notification timelines and the importance of reaching same on a continuous basis. Notifications are included as an agenda item on both weekly Staff Meeting and Community Management Meeting agendas.
- One alternative staff member trained in the HSE designated training course as an additional resource and support to the Designated Officer.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
- All money management assessment will be completed by March 19th 2021 in line with new CMSN Personal Finances and Possessions Policy.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: - New fire drill template implemented on 19/02/2021 with prompts for important information and to highlight key learnings. - Fire drills to be reviewed at team meeting to ensure actions and learnings are followed through. Process started as of March 1st 2021. - Fire drills to be reviewed at local community management meetings. - Fire drills to be audited quarterly.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: - Clinical Support Officer is due to visit community on 02/04/2021 to meet each House Co-Ordinator individually to schedule a full review of all Positive Behavioural Support Plans. - Review dates will be scheduled over the next 6 months to ensure all PBSP have been reviewed in that time frame. The schedule will be prioritised by complexity of presenting behaviours. - This will be reviewed monthly with the Clinical Support Officer and the management team at Community Management Meetings. Any changes in presenting behaviours for community members in the preceding month will be discussed and plans adjusted as necessary. - A PBSP is in the process of being developed and will be implemented for one particular Community Member where it has been identified that there has been a significant increase in Behaviours of Concern leading to incidents resulting in Safeguarding concerns.	
Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
- A safeguarding action plan will be in place by 19/03/2021, as will detail the schedule to review all current safeguarding plans, to include all safeguarding plans overdue a review to be completed by 30/04/21. Priority to be given to repeat safeguarding incidents. The implementation of this plan will be managed by the PIC and overseen by the Regional Manager and Regional Safeguarding Lead.
- PIC to complete a monthly review of safeguarding incidents, informed by the Designated Officers monthly analysis of safeguarding incidents, with appropriate escalations and/or referrals to be made as identified. Analysis findings and actions proposed/taken to be presented to the monthly Community Managers meeting attended by regional managers from CCoI Clinical, Operations and Safeguarding Teams to ensure cross functional input and oversight.
- Safeguarding incidents and open safeguarding plans to be reviewed at weekly staff team meetings to ensure the care and support team are aware of the Open Safeguarding Plans and the safeguarding measures to be maintained by them for the community members with supports whom they support.
- All intimate care plans to be reviewed, and updated as necessary, by 30/04/21.

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
Registration Regulation 7(2)(b)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 3.	Not Compliant	Orange	31/03/2021
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	31/03/2021

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.	Not Compliant	Orange	31/05/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/06/2021
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	31/03/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	24/03/2021

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2021
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	Orange	31/03/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/06/2021
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	31/03/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated	Not Compliant	Orange	31/03/2021

	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 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	30/04/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	01/03/2021
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at	Substantially Compliant	Yellow	01/03/2021

	suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/03/2021
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.	Not Compliant	Orange	30/04/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the	Not Compliant	Orange	30/09/2021

	cause of the resident's challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/04/2021